



# POLARIS PULSE®

*A Bi-monthly Informational Bulletin Brought To You By Polaris Group*

## The Who, What, When, Why & How of the National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard unique health identifier to health care providers. HHS published the Final Rule adopting the National Provider Identifier (NPI) as the standard identifier in January 2004.

**Beginning May 23, 2007 (May 2008 for small health plans), the NPI must be used in lieu of legacy provider identifiers.** Legacy provider identifiers include:

- Online Survey Certification and Reporting (OSCAR) system numbers
- National Supplier Clearinghouse (NSC) numbers
- Provider Identification Numbers (PINs)
- Unique Physician Identification Numbers (UPIN) used by Medicare

Legacy numbers do not include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs)
- Social Security Numbers (SSNs)

### **Who**

All health care providers are eligible to receive an NPI. Only health care providers that transmit health information in electronic form in connection with a covered transaction are required to obtain an NPI. Examples of health care providers include: Physicians, Nurse Practitioners, Hospitals, Nursing Homes, Suppliers of Durable Medical Equipment, and Pharmacies.

The final rule does not include billing services as health care providers, thus they are not eligible for NPIs.

### **What**

The NPI is a 10-digit number that will be used to identify the health care provider to health care

partners, including all payers, in all HIPAA standard transactions. The NPI will replace the identifiers currently used in HIPAA standard transactions conducted with Medicare and with other health plans. There are two types of health care providers in terms of NPIs:

1. Type 1— Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
2. Type 2 – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.
  - Organizations must determine if they have “**subparts**” that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization that furnishes health care and is not itself a separate legal entity.
3. An individual who is a health care provider and who is incorporated, may need to obtain an individual NPI (Type 1) and an NPI for the corporation or LLC (Type 2).

### **When**

**NPIs are now required prior to enrolling with Medicare.** An NPI number is a required field on all revised (04/06) enrollment applications. A copy of the NPI notification furnished by the (National Plan and Provider Enumeration System (NPPES) is a required attachment for all CMS-855 forms submitted after May 1, 2006. Although an NPI number is now required for Medicare enrollment, claims submitted before October 2, 2006 must still include an existing legacy Medicare number.

For current providers, the NPI compliance date is

*For more information, please contact your Polaris Group representative.*

**May 23, 2007 for most health care providers and May 23, 2008 for small health plans** (less than 5 million dollars in annual revenues). CMS recommends that covered entities obtain an NPI at least six months prior to the implementation date to provide ample time to test the NPI and share it with all health care partners, including payers, clearinghouses, vendors, and other providers.

**Why**

The NPI is an Administrative Simplification mandate of HIPAA.

**How**

There are three ways to obtain an NPI.

1. Complete the **on-line application** at the **N P P E S** **w e b s i t e** (<https://NPPES.cms.hhs.gov/NPPES/Welcome.do>);
2. Download the **paper application** form at [www.cms.hhs.gov/NationalProvIdentStand/](http://www.cms.hhs.gov/NationalProvIdentStand/) and mail it to the address on the form; or,
3. After asking you for your permission, authorize an employer or other trusted organization to obtain an NPI for you through bulk enumeration, or **Electronic File Interchange (EFI)**.

Regardless of how the NPI is obtained, it is important to **retain the notification document that NPPES provides with your NPI**. This notification may need to be shared with other health care partners.

**NPI Timeline**

**Stage I**

*May 23, 2005 - January 2, 2006*

Providers must submit Medicare claims using only the existing **Medicare** numbers. CMS claims processing systems rejected any claim that included an NPI during this phase.

**Stage II**

*January 3, 2006 - October 1, 2006*

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim**. Note that CMS claims processing systems will reject, as unable to process, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

**Stage III**

*October 2, 2006 - May 22, 2007*

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.

Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

**Stage IV**

*May 23, 2007 - Forward*

CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

\*\*\*\*\*

**Standard Paper Remittance Advice**

Beginning June 1, 2006, the Standard Paper Remittance Advice (SPR) received through the mail will no longer be available to providers/suppliers who also receive an Electronic Remittance Advice (ERA), whether the ERA is received directly or through a billing agent, clearinghouse, or other entity representing a provider/supplier. In response to the provider/supplier communities continued need for SPRs, CMS has developed free software call Medicare Remit Easy Print (MREP) that gives providers/suppliers a tool to read and print a remittance advice (RA) from the HIPAA compliant Health Care Claim Payment/Advice (835) file. The MREP software was designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. CMS worked with other payers to insure their acceptance of the SPR generated by the MREP software for Coordination of Benefit claim submission. Additionally, CMS has worked with clearinghouses to assure similar software is available to read and print an ERA for those providers/suppliers that utilize clearinghouse services.

CMS encourages providers/suppliers currently receiving the ERA, who don't use software to read and print RAs from these files, to begin using MREP or other similar software. Go to your Medicare carrier or

*For more information, please contact your Polaris Group representative.*

DMERC's website for further information regarding MREP software.

\*\*\*\*\*

**Medicare Part B versus Medicare Part D  
In the Long Term Care Setting**

In order to simplify access to the Part D drug benefit in the long term care (LTC) setting, CMS recommends the physician order include a statement of status such as "Nursing Home Part D" for drugs administered through a Part B covered item of durable medical equipment (DME) such as a nebulizer or pump. Medicare Part B only covers these drugs when used in conjunction with DME in the beneficiary's home. LTC facilities do not qualify as a beneficiary's home.

Medicare Part B also covers injectables and infusible drugs that are furnished incident to a physician's service. If the LTC facility rather than the physician furnishes and administers these drugs to a non-Part A beneficiary, CMS recommends including a statement of status such as "Administered by Facility, Nursing Home Part D".

For Part B also covers certain oral anti-cancer drugs, certain oral anti-emetics related to chemotherapy, and immunosuppressive drugs for transplants paid for by Medicare. CMS recommends including in the written prescription both the diagnosis and the indication as well as the statement of status as "Part B" or "Part D". As an example, Methotrexate for rheumatoid arthritis should have the diagnosis specified, and the designation "Part D" added to the prescription.

Coverage of the above categories remains subject to the terms of the beneficiary's Prescription Drug Plan.

**SOLUTION CENTER Q&A**

**"Where No Question Goes Unanswered"**

**Q:** May Nurse Practitioner (NP) perform the initial comprehensive visit in a SNF and may they sign the initial orders for a SNF resident?

**A:** The Social Security Act states that the medical care of every resident must be provided under the supervision of a physician. Congress did not extend this requirement to NPs in a SNF. Although NP may not sign initial orders for a SNF resident, they may write initial orders for a resident only when they review the orders with the attending physician in person or via telephone and have the orders signed by the physician.

**TELECONFERENCE TRAININGS**

Polaris Group is pleased to present the following *CEU approved* teleconference trainings

**Live Teleconference Trainings**

<u>Topic</u>	<u>Date</u>
Case Management for 53 RUGs	6/1
Medicare Billing Introduction	6/6
Your QA/CQI Program	6/8
Medicare Billing Practicum	6/13
Quality Indicator/Measure Report	6/15
Consolidated Billing	6/20
Behavior Assessments and Care Planning	6/21
Super Supervisor	6/22
New Activity Protocol and Psychosocial	6/28
Falls Management	7/6
Medicare Skilled Nursing Documentation	7/11
Event Management	7/12
Pressure Ulcer Management	7/13
Section I, J, O, and W	7/18
Med. Director and QAA Protocol	7/19
Urinary Incontinence	7/20
Part B Cap and Billing	7/25
How to have a successful FI Review or Appeals	7/25
QA Audits: What To Do When	7/26
Pain Management	7/27
Managing New Adm. & Acute Episodics	7/27

*Please join us in our Teleconferences .  
For further information regarding these seminars,  
please contact the  
Seminar Department at: 800-275-6252 ext. 233  
Or register at: [www.polaris-group.com](http://www.polaris-group.com)*



**POLARIS GROUP™**  
Strategic solutions for health care

**POLARIS PULSE** is a bi-monthly, informational newsletter distributed to **POLARIS GROUP** clients. For further information regarding services or information contained in this publication, please contact **POLARIS GROUP** corporate headquarters at 800-275-6252.

**Contributors:**

Gayle Atherton  
Victor Kintz  
Marty Pachciarz

**Editor:**

Chuck Cave

**Production Manager**

Cindy Hernandez

*For more information, please contact your Polaris Group representative.*