



# POLARIS PULSE®

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

## CMS Announces NPI Data Dissemination Policy

CMS published the long awaited NPI Data Dissemination Notice in the May 30, 2007 Federal Register, Volume 72, No. 103.

### **National Plan and Provider Enumeration System (NPES) Data Dissemination**

The National Plan and Provider Enumeration System (NPES) enumerates health care providers and houses National Provider Identifiers (NPIs) and information from NPI applications/updates. Under the Health Insurance Portability and Accountability Act (HIPAA) covered entities are required to use NPIs to identify health care providers in standard transactions. The NPI Final Rule required CMS establish a data dissemination process.

Entities wishing to obtain the NPI of a health care provider for use in a standard transaction(s) may contact that health care provider directly and request the NPI. Health care providers who are covered entities under HIPAA are required by the NPI final rule to disclose their NPIs to any entity that needs them for use in standard transactions.

The NPI Final Rule required CMS develop a process for disseminating NPI information in accordance with the Freedom of Information Act (FOIA), the Privacy Act, and the CMS FOIA and Privacy Act procedures. Health and Human Services (HHS) has reviewed the health care provider data elements contained in the NPES and determined the following information is not disclosable under the FOIA:

- Social Security Numbers (SSNs)
- Internal Revenue Service Individual Taxpayer Identification Numbers (IRS ITINs)
- Dates of birth (DOB)

HHS will not release these three data elements; however, HHS has determined that the remaining health care provider data elements contained in the NPES are required to be disclosed under the FOIA. The list of disclosable data elements is available in the May 30, 2007 Federal Register beginning on page 30012.

*Some health care providers may wish to delete optional NPES data that they furnished when applying for their NPIs since the information provided in these optional fields is not required.*

Data contained in the “Other Names” and “Other Provider Identifiers” data fields are optional. Further, a primary “Healthcare Provider Taxonomy Code” is required to be furnished when applying for an NPI; however, the reporting of additional “Healthcare Provider Taxonomy Codes” is optional.

Health care providers who are covered entities under HIPAA are required by the NPI final rule to update their NPES data within 30 days of the changes.

### **The HHS NPES data dissemination policy is as follows:**

1. *NPES health care provider data that are required to be disclosed under the FOIA will be available as a downloadable file on a web site.*

The location of the downloadable file will be announced on the CMS NPI web page (<http://www.cms.hhs.gov/NationalProvIdentStand/>) prior to its availability.

Each month, an update file will also be available for download from the same web site. The update file will not replace the initial file. The update file will contain only data that are required to be disclosed under FOIA for health care providers who obtained NPIs within the prior month, and

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updates and changes to the data that are required to be disclosed under the FOIA for enumerated health care providers that were made within the prior month. The first update file will be available for downloading 30 days after the availability of the initial file, and a new update file will be available for downloading each month thereafter.

There will be no charge to download the files. CMS may decide to discontinue making these files available if it is determined that the query-only database is an adequate replacement.

2. *NPPES health care provider data that HHS has determined are required to be disclosed under FOIA will be available in a query-only database on an internet web site.*

Users will be able to run simple queries online, such as queries by NPI and by name of health care provider. There will be no charge to use the query-only database.

3. *Other requests for NPPES health care provider data that HHS has determined are required to be disclosed under the FOIA.*

Requests for FOIA-disclosable data in formats or in media that are not described above, or any other custom requests, will be considered in accordance with the FOIA and CMS FOIA procedures and charges.

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### **Medicare Claims Processing Manual SNF Inpatient Part A Billing**

On May 25th CMS published Transmittal 1252 to update select sections of Chapter 6, SNF Inpatient Part A Billing, including the following language identified by *italic print*:

- **Section 30.1—Health Insurance Prospective Payment System (HIPPS Rate Code)** - The SNF may bill the program only after:

- *An assessment has been completed and submitted to the State RAI Database;*
- *A Final Validation Report indicating that the assessment has been accepted by the state; and*
- *The covered day has actually been used.*

*SNFs that submit claims that have not completed this process will not be paid. It is important to remember that the record will be accepted into the State RAI database, even if the calculated RUG code differs from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG code. When such discrepancies occur, the RUG code reported on the Final Validation Report shall be used for billing purposes.*

- **Section 40.3.3—Same Day Transfer**

*No payment is made to the originating participating provider. Instead, the participating provider to which the patient was transferred counts the admission day as a utilization day that includes the day of admission and may bill the HIPPS default code.*

*If a patient is transferred from a Medicare participating facility to a nonparticipating facility the day of admission counts as a utilization day and the Medicare-participating facility may bill the HIPPS default code.*

- **Section 40.8– Billing in Benefits Exhaust and No-Payment Situations**

*Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 and room & board charges only. No further ancillary services need be billed on these claims.*

For No Payment Bill type 210

*Occurrence Span Code 74 = include the statement covers period of this claim*

- **Section 90.1—Beneficiaries Disenrolled from MA (Medicare Advantage) Plans**

*If a beneficiary voluntarily or involuntarily disenrolls from a risk MA plan while an inpatient of an SNF and converts to original Medicare (i.e., fee for service) the requirement for a three day hospital stay will be waived if the beneficiary meets the level of care criteria found in 42 CFR 409, Subpart D, up through the effective date of the disenrollment. The beneficiary will then be eligible for the number of days that remain out of the 100 day SNF benefit for that particular SNF stay minus those days that would have been covered by the*

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program under original Medicare while the beneficiary was enrolled in the risk MA plan. However, in cases where the beneficiary disenrolls from a risk MA plan after discharge from the SNF, and then is readmitted to the SNF under the 30 day rule, all requirements for original Medicare (i.e., fee for service), including the 3-day hospital stay must be met. Rules regarding cost sharing apply to these cases. That is, providers may only charge beneficiaries for SNF coinsurance amounts.

If the beneficiary voluntarily disenrolls from a risk MA plan and converts to original Medicare (i.e., fee for service) before admission to a SNF then the beneficiary must meet **all** original Medicare requirements for a SNF stay, including that of a three day inpatient hospital stay.

SNFs submit the first fee-for-service inpatient claim with condition code "58" to indicate a patient was disenrolled from an MA plan and the 3-day prior stay requirement was not met. Claims with condition code 58 will not require the 3-day prior inpatient hospital stay.

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**SOLUTION CENTER Q&A**  
**"Where No Question Goes Unanswered"**

- Q:** If a resident goes home for an overnight stay during a Medicare Part A covered stay, can the facility bill the resident privately for that day? How should the leave of absence (LOA) be coded on the claim?
- A:** The SNF cannot bill the resident for the LOA day (s). The days are shown on the Medicare claim with a revenue code 018X and LOA days as units. Charges for the LOA day(s) are shown as zero on the claim. Occurrence span code 74 is used to report the LOA from and through dates.
- Q:** Are taxonomy codes required for UB-04 SNF claims?
- A:** Medicare does not require Taxonomy Codes on all SNF UB-04 Claims. Taxonomy codes are required for institutions with subparts. Medicare providers who submit claims for their primary facility and its subparts must report a taxonomy.

**TELECONFERENCE TRAININGS**  
 Polaris Group is pleased to present the following  
**CEU approved** teleconference trainings  
**Live Teleconference Trainings**

<u>Topic</u>	<u>Date</u>
ADR—Part One	6/14
Tame the Care Plan Monster	6/15
Managed Risk	6/19
ICD 9 Codes	6/20
ADR—Part Two	6/21
QA Audits that Work	6/26
ICD 9 Codes—Part Two	6/27
ADR—Part Three	6/28
<b>NEW MDS "FAST TRACK" TRAINING:</b>	
MDS Fundamentals	7/10
MDS Coding	7/12
RAPS and Care Planning	7/17
Medicare Basics	7/19
Nursing Documentation	7/24
MDS/Case Management	7/25
QI/QMs Review	7/26
F-Tag Review	7/31
Survey Process & Preparation	8/1

*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)*



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