ISSUE BRIEF

Medicare/Medicaid Technical Assistance #90:

A Brief Guide to the National Provider Identifier Number (NPI) for Health Centers

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Another milestone in implementing provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) was marked on May 23, 2007, as that was the deadline for compliance with the National Provider Identifier (“NPI”) Rule. While the Centers for Medicare and Medicaid Services (“CMS”) has published a substantial amount of guidance on the NPI (see references on page 11), the National Association of Community Health Centers (“NACHC”) continues to receive inquiries from health centers. NACHC’s Department of Federal and State Affairs has prepared this Issue Brief to address key features of the NPI Rule as it applies to health centers and to their affiliated health care practitioners.

1. What is the purpose of the NPI?

The NPI is one of the “administrative simplification” provisions mandated by HIPAA. HIPAA required the Department of Health and Human Services (“DHHS”) to adopt national standards for electronic health care transactions and code sets as well as a standard unique identifier for a health care provider to use in conducting electronic health care transactions that are covered by HIPAA. The HIPAA-covered transactions are:

- health care claims or equivalent encounter information
- health care payment and remittance advice
- coordination of benefits
- health care claims status
- enrollment or disenrollment in a health plan
- eligibility for a health plan
- health plan premium payments
- referral certification and authorization
- first report of injury
- health claims attachments.

These HIPAA-covered transactions generally are referred to as “standard transactions.”

Health plans, including Medicaid, Medicare, and private health plans, typically assign identification numbers to participating providers of health care services. Historically, the assigned identifiers frequently were not standardized within a single health plan nor across health plans, which resulted in a health care provider having a different identification number for each health plan in which they participated, and sometimes having multiple identification numbers issued by the same health plan. The NPI is intended to simplify electronic health care transactions by replacing all other provider numbers (commonly referred to as “legacy numbers”) that a health plan (including Medicare, Medicaid, and private health plans) previously used to identify a health care provider in an electronic standard transaction.

2. Who is eligible to obtain an NPI?

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Any individual or organization that provides medical and other health services as defined by Section 1861(s) of the Social Security Act (which includes federally qualified health center services) and any other person or organization that furnishes, submits bills for, or is paid for health care in the normal course of business is eligible to obtain an NPI. Thus, there are two categories of health care providers that may obtain an NPI: organization health care providers, such as health centers, hospitals, pharmacies, laboratories, nursing homes, etc., and individual health care providers, such as physicians, dentists, nurse practitioners, chiropractors, pharmacists, and other health care practitioners who provide health services as defined in the Social Security Act.

Health care providers who are individuals obtain one NPI for life. Organization health care providers ordinarily would obtain at least one NPI covering the entire organization, but may obtain an NPI for operational units of the organization (referred to as “subparts” for NPI purposes) under certain circumstances, so long as the NPI for any subpart is not identical to that of another subpart. Subparts are discussed in more detail below.

It is important to note that not all health care providers who are eligible to obtain an NPI are necessarily required to obtain an NPI. Moreover, obtaining an NPI – either as an organization or an individual – does not replace the procedures otherwise required for a health care provider to enroll in Medicare, Medicaid, or a private health plan. Conversely, some health plans, notably Medicare, may require a health care provider to have an NPI as a condition to enrolling in the plan.

3. Under what circumstances is a health center required to have an NPI?

A health center that is a “covered health care provider” for HIPAA purposes must obtain and use an NPI to identify the health center when an identifier is required in any electronic standard transaction (identified in Question # 1).

A health center is a “covered health care provider” if it transmits (including within the health center) any health information (including information related to payment for the provision of health care) in electronic form in connection with a standard transaction. Thus, a health center that only receives health information electronically, such as electronic remittance advice or electronic funds transfer from a health plan, but does not conduct any other standard transactions electronically would not be a “covered health care provider” under HIPAA and would not have to obtain and use an NPI (nor comply with any other HIPAA requirement).

Note that an NPI is required even if a health center or other covered health care provider uses a business associate, such as a billing company, to conduct an electronic standard transaction on its behalf. Further, if the health center uses a business associate to conduct an electronic standard transaction, it must require the business associate to use the health center’s NPI and other NPIs appropriately, as required by the transactions that the business associate conducts on behalf of the health center.

4. What is a “subpart” of a health center under the NPI Rule?
As previously noted, the NPI Rule requires an organization that is a covered health care provider, i.e., a health care provider that engages in electronic standard transactions, to obtain an NPI for the organization. For purposes of the NPI, a “subpart” is simply a component of an organization health care provider that has a separate physical location, or that provides a different type of health care, e.g., home health services, or that requires separate licensure, e.g., a laboratory, and is not itself a separate legal entity. Thus, a health center site, laboratory, or other component may qualify for designation as a “subpart.”

However, a health center is required to designate a site or other separate component as a subpart and obtain an NPI for that subpart only in certain circumstances (See question # 5)

Individual health care providers affiliated with a health center, such as physicians and nurses, are never subparts of the health center as they are treated as a separate legal entity under the NPI Rule.

5. Under what circumstances must a health center obtain an NPI for a “subpart” of the health center?

The NPI Rule requires an organization health care provider, such as a health center, to obtain an NPI for a subpart of the organization if the subpart conducts electronic standard transactions separate from the “parent” organization. For example, a health center pharmacy or laboratory that engages in an electronic standard transaction with a health plan in its own right must have its own NPI. On the other hand, the NPI Rule would not require an individual health center site to have an NPI unless the site engaged in its own electronic standard transactions.

However, the commentary to the NPI Rule and subsequent CMS guidance indicate that, in situations where federal statutes or regulations require health care providers to have unique billing numbers, organization health care providers should designate those components as subparts and obtain an NPI for the subpart. In short, if the government required a “legacy number” for a health center site or component (such as Medicare FQHC sites), a health center should obtain an NPI for the site or component and use the NPI in electronic standard transactions. Moreover, as CMS currently individually designates health center sites for Medicare purposes, CMS has indicated that a separate NPI is required for each health center site that is designated as a Medicare FQHC.²

In sum, a health center must obtain an NPI for a site if:

- the site was designated as Medicare FQHC site and has a “legacy” Medicare FQHC number
- the site is newly designated as a Medicare FQHC site

² Additional guidance on determining subparts for Medicare purposes can be found at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf.
In a State Medicaid Director letter dated August 9, 2007, CMS reminded State Medicaid Agencies that they cannot dictate how providers enumerate subparts. Accordingly, CMS stated that a State may encourage, but may not require, subpart enumeration to mirror the Medicaid agency’s provider enrollment and assignment of current legacy provider numbers. See the State Medicaid Director letter available on the CMS website, http://www.cms.hhs.gov/SMDL/downloads/SMD080907A.pdf.

A health center may identify subparts in addition to those required to be designated depending on its business needs. (For a further discussion of subparts, see the Workgroup for Electronic Data Interchange (“WEDI”) white paper on NPI Subpart Designation for Organizations, available on the WEDI website, www.wedi.org.)

6. Under what circumstances is it necessary for an individual health care provider affiliated with a health center to obtain an NPI?

It is advisable for health centers to encourage, if not require, their providers who are eligible to obtain an NPI to do so. When a health center is required to identify a treating, referring, or prescribing provider in an electronic standard transaction, such as billing, the NPI must be supplied as the provider identifier. Absence of the NPI will delay processing of claims. Most individual health care providers affiliated with a health center as an employee, contractor, or volunteer, are likely to be eligible for an NPI. Thus, while health center employed providers are not legally required to obtain an NPI (unless they engage in an electronic standard transaction in their own right), it is in the health center’s interest to ensure that its providers who are eligible to obtain an NPI do so. (Contractors and volunteers may have an NPI because they may conduct an electronic standard transaction outside of their affiliation with the health center.)

7. How does a health care provider obtain an NPI?

Health care providers can apply for an NPI in one of three ways:

- Via the Internet by logging on to the National Plan and Provider Enumeration System (“NPPES”) at www.nppes.cms.hhs.gov
- By submitting a paper application to the NPI Enumerator (Fox Systems, Inc.) at:

  NPI Enumerator
  P.O. Box 6059
  Fargo, North Dakota 58108-6059
  Tel. 1-800-465-3203
  TTY 1-800-692-2326
  E-mail: customerservice@npienumerator.com

  A copy of the paper application is available at www.nppes.cms.hhs.gov or may be obtained from the NPI Enumerator.
• By using the service of an Electronic File Interchange Organization ("EFIO") approved by CMS. An EFIO has the capacity to submit NPI application information for multiple health care providers at one time in a single electronic file.

When applying for an NPI, it is important that health care providers supply all of their legacy numbers as that will facilitate the development of crosswalks to aid in the transition to the NPI.

8. Is a health center with an NPI required to update the information in the National Plan and Provider Enumeration System ("NPPES")?

Yes. A health care provider that is a “covered health care provider,” i.e., a health care provider that conducts electronic standard transactions, must communicate a change in any of the information that the provider is required to submit in order to obtain an NPI to the NPPES within 30 days of the change. A health center that has obtained an NPI for a subpart must communicate any changes with respect to the subpart within the 30-day period. Health care providers who have an NPI but are not a “covered health care provider” are not required to submit changes to NPPES, but are encouraged to do so in order to maintain the accuracy of the NPPES data. Health centers should consider periodically reviewing data submitted to the NPPES to validate its accuracy and encourage their affiliated health care providers to do so.

9. Is a health center required to make its NPI available to other health care providers?

Yes. A health center, and any other “covered health care provider,” is required to disclose its NPI, when requested, to any person or entity that needs the NPI to identify the health center (or other covered health care provider) in an electronic standard transaction, such as other covered health care providers, clearinghouses, and health plans. This might occur, for example, when a laboratory needs the NPI of a referring health care provider for billing purposes. A health center that has obtained an NPI for a subpart must assure that the subpart discloses its NPI as required. CMS encourages all health care providers with an NPI to freely disclose them so as to improve the efficiency of the health care system.

10. Is a health plan required to use a health center’s NPI?

Yes. A health plan must use the NPI of any covered health care provider, or subpart of an organization provider, on all electronic standard transactions where that health care provider’s identifier is required. Moreover, a health care plan may not require a health care provider that has been assigned an NPI to obtain an additional NPI. However, CMS has allowed health plans with a contingency plan until May 23, 2008 to fully implement the NPI Rule. Accordingly, it is very important for health centers that engage in electronic standard transactions with health plans to understand the contingency plan, if any, of the plans in which they participate. (See below for a further discussion of NPI contingency plans.)
11. Can a health plan require a health center (or other health care provider) to use an NPI for paper (non-standard) transactions?

Yes. While the NPI Rule does not apply to paper (non-standard) transactions, it does not prevent a health plan from requiring a health care provider to use an NPI as an identifier in non-standard transactions. For example, a health plan could require a health care provider to use an NPI through a provider contract or as a condition of participation in the health plan.

12. Is a provider’s NPI and information that a health care provider supplies when obtaining an NPI available to the public?

Yes. This will enable entities to obtain the NPI of a health care provider when the NPI is needed for a standard transaction, but access to NPIs and the NPPES data is not limited to HIPAA-covered entities. CMS will disclose information in the NPPES that is disclosable to the public under the Freedom of Information Act (“FOIA”).

Generally, the disclosable information includes the provider’s name, address, and official contact information, business location and business mailing address, health care provider taxonomy code(s), other provider identifiers (i.e., legacy numbers), gender, license number, date NPI was obtained, and date of last update of the NPPES data. CMS will not disclose the Social Security Number or the Internal Revenue Service Taxpayer Identification Number of an individual health care provider nor the individuals’ date of birth.

NPPES data information will be available in two forms: a real time query-only database, known as the NPI Registry, and a downloadable file of NPPES data for all health care providers who have obtained an NPI. There is no charge, and user IDs and passwords are not required to use either database.

The NPI Registry is scheduled to be operational on September 4, 2007. It can be found at www.nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. The downloadable file will be available approximately one week after the NPI Registry becomes operational. It can be found at www.nppesdata.cms.hhs.gov/cms_NPI_files.html. The downloadable file will be updated every month.

Technical information on NPI data dissemination can be found at the CMS NPI website: www.cms.hhs.gov/NationalProvIdentStand/

13. What is the deadline for a health center (or other covered health care provider) to start using their NPI?

The final deadline for HIPAA-covered entities (other than small health plans)\(^3\) to comply with the NPI Rule was May 23, 2007. Covered transactions that require a health care provider’s identifier that are transmitted containing only legacy identifiers or containing both legacy identifiers and NPIs would be noncompliant.

\(^3\) A small health plan is defined, for HIPAA purposes, as a health plan with annual receipts of $5 million or less.
14. What happens if a health center or other covered health care provider does not use an NPI in an electronic standard transaction after May 23, 2007?

As with the other HIPAA-mandated administrative simplification provisions, the Secretary of the Department of Health and Human Services has authority to impose civil monetary penalties on HIPAA-covered entities that do not comply with the respective rules, unless such an entity has made reasonable efforts to comply and has not been willfully negligent.\(^4\) The Secretary has delegated authority to the Administrator of CMS to enforce the NPI Rule. In that regard, CMS has established a complaint-driven approach to enforcement. Accordingly, when CMS receives a complaint alleging a failure to comply with the NPI Rule, it will notify the entity in writing of the complaint and, before imposing any monetary penalties, give the entity the opportunity to demonstrate compliance, document its good-faith efforts to comply, and/or submit a corrective action plan.

Furthermore, CMS has announced that, for a 12-month period (through May 23, 2008), it will not impose penalties on a HIPAA-covered entity that deploys a “contingency plan” if the entity has made reasonable and diligent efforts to become compliant and, in the case of health plans (that are not small health plans), to facilitate compliance with their trading partners. In short, CMS is giving health plans and participating health care providers that make a good-faith effort (applying CMS’s standards) up to another year to come into compliance, during which time they can continue to use legacy numbers when conducting standard transactions.

15. How does a health center implement a contingency plan?

CMS does not prescribe specific elements of a contingency plan. The essence of a contingency plan essentially is a good-faith effort to achieve compliance with a strong emphasis on sustained actions and demonstrable progress, based on individual circumstances. However, according to CMS, indications of good faith for a covered health care provider, such as a health center, might include such factors as having obtained an NPI and having the ability to use it on HIPAA transactions or increased external testing with trading partners.

As with all compliance-related activities, it is critical to adequately document all aspects of a contingency plan.

CMS announced its contingency plan policy on April 2, 2007.\(^5\) Therefore, a health center (or other covered health care provider) that did not obtain a required NPI by the May 23, 2007 compliance date may have some difficulty in establishing “good faith.” However, it is unlikely that a complaint of noncompliance with the NPI Rule filed by a health plan or another health center trading partner before May 23, 2008 will result in the imposition of monetary sanctions. As a practical matter, the greater compliance risk for health centers that do not obtain and use an NPI in electronic standard transactions (and assure compliance by subparts) is that they may well

\(^4\) Penalties for violation of HIPAA requirements are established by statute, up to $100.00 per violation and not more than $25,000 in a calendar year for all violations of an identical requirement. See 42 U.S.C. § 1320d-5.

have health care claims, and other standard transactions necessary for payment, rejected or delayed, resulting in a disruption in cash flow.

16. How does a health plan implement a contingency plan?

It is important to distinguish obtaining an NPI from actually using the NPI in an electronic standard transaction. Many health plans are not yet ready to accept the NPI as the sole health care identifier in an electronic standard transaction and have adopted a contingency plan for handling those transactions in the interim period. It is essential that health centers understand the contingency plan that may have been implemented by every health care plan in which they participate.

A health plan (other than a small health plan that does not have to be compliant with the NPI Rule until May 23, 2008) must demonstrate a good-faith effort to achieve compliance. According to CMS, indications of good faith for a health plan might include such factors as:

- Increased external testing with trading partners.
- Lack of availability of, or refusal by, its trading partner(s) prior to May 23, 2007 to test transactions with the covered entity whose compliance is at issue.
- Concerted efforts in advance of May 23, 2007 and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider community.

Health centers should understand the features of a contingency plan, if any, for all health care plans in which they, or their affiliated individual health care providers, participate. Among other things, a contingency plan will advise participating providers when the plan will accept legacy identification numbers, NPIs, or a combination thereof, and other information pertinent to electronic standard transactions. As outreach and the provision of testing opportunities are key features of a contingency plan, it is likely that health plans have communicated this information to their participating providers directly and through their website. Nevertheless, it is incumbent on health care providers to stay up to date on the compliance status of every health plan in which they participate.

While a health plan may not use a contingency plan after May 23, 2008, it may discontinue a contingency plan at any time before that date. Therefore, it is very important that health centers and other participating providers be aware of when a health plan will begin to accept only the NPI as a required identifier to avoid unnecessary rejection of claims and other processing delays.

17. Does Medicare or Medicaid have a contingency plan?

State Medicaid Agencies may implement a contingency plan as appropriate for the state. In a State Medicaid Director letter dated August 9, 2007, CMS instructed State Medicaid Agencies that choose to implement a contingency plan to follow the CMS guidance dated April 2, 2007, and requested State Agencies that have implemented a contingency plan to notify CMS. See the contingency plan guidance on the CMS website, http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf.

**NOTICE**

The information in this Issue Brief is believed to be accurate and current as of the October 2007 publication date. It is important that health centers stay abreast of further developments as full implementation of the NPI Rule continues through May 2008.

**RESOURCES**

The CMS website has substantial information on the NPI, including frequently asked questions (“FAQ”) and links to other resources, including the Medicare Learning Network. Go to: www.cms.hhs.gov/NationalProvIdentStand/.

The Workgroup for Electronic Data Interchange (“WEDI”) has published numerous papers and other material on the NPI and related issues. Go to: www.wedi.org

Health center fiscal intermediaries maintain a variety of resources on the NPI. For National Government Services go to: http://www.adminastar.com/. For Noridian Administrative Services go to: https://www.noridianmedicare.com/.