CMS Manual System

Pub 100-20 One-Time Notification Transmittal Sheet

Transmittal 204

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 1, 2006

Change Request 4320

NOTE: Transmittal 180 dated September 23, 2005, is rescinded and replaced with Transmittal 204 dated February 1, 2006. The previous transmittal was not to be posted on the Internet. The information can now be posted and shared. References to "confidentiality" have been removed, a requirement for a Medlearn article is added, and there is a correction to the NUCC date for full use of the revised CMS-1500 paper claim form. All other material remains the same.

SUBJECT: Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms

I. SUMMARY OF CHANGES: This CR rescinds and replaces CR 4004. This instruction contains those requirements applicable to Stage 1 of carrier, DMERC, Fiscal Intermediary, and shared system maintainer implementation of the National Provider Identifier (NPI). During this first stage, NPI will be accepted on claims but will not be used for Medicare processing. When an NPI is received on a claim, it is to be issued in Coordination of Benefit transactions issued in response to that claim. This instruction also includes information about Stages 2 (October 2006) and 2 (May 23, 2007) to assist with Stage 1 programming.

NEW/REVISED MATERIAL

EFFECTIVE DATE: *January 1, 2006

IMPLEMENTATION DATE: January 3, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
N/A	

III. FUNDING:

Funding for Medicare contractors is available through the regular budget process for costs required for implementation.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 204	Date: February 1, 2006	Change Request 4320

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SUBJECT: Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms

I. GENERAL INFORMATION

A. Background:

NOTE: This CR rescinds and replaces CR4004. CR 4004 was originally published on August 12, 2005 as transmittal number 172. Subsequent to its release, CMS was notified of the need to modify many of the business requirements and related policy information and to:

- Clarify when version 4010 outbound files may be modified for reporting of NPIs in X12 276 and 837 COB transactions;
- Correct the policy item indicating that non-HIPAA format electronic claims might be accepted by Medicare in January 2006. This will not be the case due to recent termination of the Medicare HIPAA claim transition plan effective October 1, 2005;
- Reinsert 1G (UPIN) as an acceptable qualifier for referring and ordering physicians; and
- Reflect a recent change in the WEDI Dual NPI-Legacy Identifiers paper advocating that the provider loop of X12 276 and 277 transactions be repeated by providers and payers to enable reporting of both an NPI, when available, and the provider's legacy identifier.

NOTE: CR 4004 was republished as transmittal number 180 on September 23, 2005 with the changes as listed above. Transmittal 180 totally replaced transmittal 172. Both transmittals (172 and 180) were issued as confidential transmittals. It has now been determined that the contents of CR 4004/transmittal 180 should no longer be kept confidential and may be shared in total with the public. It is being reissued as a "non-confidential" CR which is identical to the version issued on September 23, 2005, except for deletion of the references to confidentiality, a requirement for issuance of a Medlearn article to providers, and a correction in the NUCC date for full use of the revised CMS-1500 paper claim form.

None of these changes impact carrier, DMERC, FI or shared system implementation of CR 4004 which was completed by January 3, 2006. To avoid public confusion concerning the different transmittal numbers previously assigned to CR 4004, a new CR number (4320) has been issued to the non-confidential version of the CR 4004 requirements.

Subsequent to August 12, it also became evident that shared system maintainer hours would be required during the January release period for analysis of NPI data and participation in efforts to develop the NPI to legacy number crosswalk which will be needed for Medicare claims and other EDI transaction processing beginning in October 2006. Although CR 3892 provided for shared system maintainer hours for this effort, the hours in CR 3892 were for the October release period only. Hours will also be needed for this purpose in subsequent releases pending completion of the crosswalk design and determination of usage of the crosswalk in Medicare transaction processing. Rather than issue a separate NPI CR to provide for those hours, a Business Requirement was added to CR 4004/Transmittal 180 for that purpose.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care. The implementing regulation for that requirement appears in 45 CFR Part 162, Subpart D (162.402-162.414). CMS began to accept applications for NPIs at https://nppes.cms.hhs.gov and by mail on May 23, 2005, and to issue NPIs that same day. A number of articles have been issued in recent months to educate and remind physicians, suppliers and other providers on the NPI and the application process.

One of the articles indicated that providers should not begin to submit their NPIs on claims or other health care transactions until notified by particular payers that they have completed system changes as needed to eliminate the possibility that transactions with NPIs could be rejected. Medicare, as well as other health benefit payers, needs to make system changes to accept and process transactions using the NPI in lieu of those identifiers previously used to identify providers. Those prior identifiers are frequently referred to as "legacy identifiers."

CMS has endorsed the WEDI strategy for cross-health care industry implementation of the NPI as contained in the WEDI paper "Dual Use of NPI & Legacy Identifiers." The paper is available at www.wedi.org/snip/public/articles. As stated in the paper, "The objective is to make system change schedules of each trading partner independent of the other. Once transactions between two trading partners are being conducted using the dual identifier specifications, and after both partners are employing only NPI for provider identification, then with mutual agreement the legacy identifiers other than required Federal Tax IDs may be discontinued. The receiver will be capable of receiving both pre-NPI and Dual NPI-Legacy identifiers until the deadline of May 23, 2007." Under this strategy, "The sender changes its systems and starts sending the NPI as primary provider identifier and Legacy Identifier as a secondary identifier. Both the sender and receiver are still relying on the Legacy Identifier to identify the provider."

B. Policy: Medicare fee-for-service systems will follow a 4 stage process to implement the NPI:

STAGE 1 is addressed by this CR and will be effective January 1, 2006. During this stage:

- Carriers, DMERCs, FIs, and shared system maintainers will make changes as needed to make sure that X12 837 version 4010A1 claims are not rejected due to the presence of an NPI for a provider, as long as a Medicare legacy identifier for the provider is also present.

- NPIs will be edited to verify they meet basic structure requirements established for NPIs.

Impact of Stage 1 on EDI, DDE, and Paper Claim Transactions:

- X12 837 Incoming Claims and COB--X12 837 version 4010A1 claims can be submitted with a provider NPI during Stage 1, as long as they also contain a valid Medicare legacy identifier for the same provider. As indicated in the implementation guide notes for secondary identification of billing and pay-to-providers (is not required for secondary types of providers that would not receive direct payment from an insurer for the submitted claim), when an NPI is submitted in an NM1 segment, the taxpayer identification number (TIN: employer identification number or a sole proprietor's Social Security Number) must also be reported in the REF segment of that same loop. Claims may also continue to be submitted with a Medicare legacy identifier without an NPI. If a provider has more than one Medicare provider legacy identifier, the legacy identifier to be reported in the claim would be the number that would have been used to submit that claim pre-NPI.
If an NPI is submitted by a provider, the NPI, the legacy identifier, and the TIN will be forwarded in any 837 version 4010 or 4010A1 Coordination of Benefit (COB) transaction sent to one or more secondary payers.

- DDE Claims—DDE claim must continue to be submitted using the Medicare legacy identifier during Stage 1. DDE claim screens do not have a field for reporting of more than one identifier per provider.

- Non-HIPAA Format Claims—Non-HIPAA format electronic claims will not be accepted by Medicare after October 1, 2005 and will not be an issue for NPI reporting.

- NCPDP--The National Council of Prescription Drug Plan (NCPDP) format adopted under HIPAA as the standard for retail pharmacy drug claims is not able to record more than one identifier for a provider. Submitters of those claims must continue to report only the Medicare legacy identifier in the Service Provider ID (201-B1) field and the 04 (Medicare) Service Provider ID qualifier in the Transaction Header segment until Stage 2 is implemented. The UPIN qualifier must continue to be reported in 468-EZ, and the prescriber's UPIN reported in 411-DB.

- Paper Claim Forms--Neither the CMS-1500 nor the UB-92 (CMS-1450) is able to record more than one identifier per provider. The National Uniform Billing Committee (NUBC) has announced that use of the UB-04, which is able to report the NPI and a legacy identifier for each provider involved with a claim, will begin March 1, 2007. May 22, 2007 is the last day that a payer should accept a UB-92 form. The UB-04 will be the only paper form for institutional claims that may be submitted to Medicare effective May 23, 2007 and later. During the March 1-May 22, 2007 transition period, providers are encouraged to submit both the NPI and a legacy identifier in their UB-04, but only the NPI is to be entered May 23, 2007 and later. Additional information on the UB-04 can be obtained through the NUBC Web page (www.NUBC.org).

  The National Uniform Claim Committee (NUCC) has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006 and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007 and later, payers should accept only the revised CMS-1500 form. Additional information on that form is available at www.NUCC.org. The revised CMS-1500 form will also have the ability to report both an NPI and a legacy identifier for a provider.

CMS will issue CRs for implementation of both the revised CMS-1500 and the UB-04 once those forms have received Paperwork Reduction Act clearance from the Office of Management and Budget. CMS expects to have each form implemented for Medicare by the start date of the transition period announced by the NUBC and the NUCC.

Providers submitting a UB-92 or a current (non-revised) CMS-1500 paper claim prior to the end of the transition period for each new/revised form must continue to report Medicare provider legacy identifiers only on those paper claims. Many of these paper claims are processed using optical character recognition (OCR) technology. In the absence of a qualifier to identify whether an NPI or a legacy identifier is being reported on the current paper claims, it would not always be possible for that equipment to differentiate between a legacy number and an NPI. National Supplier Clearinghouse (NSC) numbers for instance are also 10 digit numbers. The new/revised paper claim forms will require the entry of an X12 provider identifier qualifier to differentiate between types of provider numbers being reported.

- X12 276/277—Both an NPI and a legacy identifier can be reported in X12 276/277 version 4010 (pending termination of the claim status termination plan and as applicable to those contractors that receive any 276 version 4010 queries) and 4010A1 claim status inquiry and response transactions if the provider identifier loop in those transactions is repeated. X12 276 submitters that report an NPI will be required to repeat the provider loop and also report the provider's Medicare legacy identifier during Stage 1. X12 276 transactions received with an NPI but without the Medicare legacy identifier during this period must be rejected. When both an NPI and a Medicare legacy identifier are received in an X12 276 transaction during Stage 1, the responding X12 277 transaction issued by Medicare must also repeat the provider loop to report both the NPI and the legacy identifier. This rule will continue to apply during Stage 2.

- X12 270/271--The eligibility inquiry and response is able to accommodate both the NPI and a legacy identifier for a provider. Providers may report the NPI in these transactions effective January 2006, as long as they also report their Medicare legacy identifier. A 271 must return the NPI and the Medicare legacy identifier when both were reported on the inbound 270. Editing and other requirements for 270/271 transactions have been separately addressed in the requirements for that implementation and do not require any action on the part of carriers, DMERCs, FIs, or shared system maintainers. This is included in this CR for informational purposes only.

  X12 835—Although shared systems are able to retrieve NPIs from the claim Store and Forward repository (SFR) during stage 1 to report those NPIs in COB transactions, they are required to use the provider files resident at the data centers as the source of provider identification information used for payments and remittance advice transactions. Pending population of NPIs in those provider files, shared systems are unable to report NPIs in 835 or standard paper remittance (SPR) advice transactions. NPIs will not be reported in X12 835 transactions prior to stage 2.

- SPRs— The SPR formats will not be modified to enable reporting of both a provider's NPI and a legacy identifier. The 835 limitation applies to SPRs as well. SPR NPI reporting will be addressed in the same separate CR that will address X12 835 NPI reporting during stage 2.

- Proprietary Error Reports—During Stage 1, continue to report only provider Medicare legacy identifiers in these proprietary error reports. Issue a proprietary message to notify a provider when a submitted NPI did not meet the NPI edit requirements in the Business Requirements.

STAGE 2 is expected to be implemented October 2, 2006, and run through May 22, 2007. Stages 2, 3 and 4 will be addressed in separate CRs but information is provided here for planning purposes. The information reported here for the later stages is subject to change in those CRs when released but is provided here for guidance purposes. Stage 2 will involve use of an NPI to Medicare legacy ID(s) Crosswalk that is to be prepared by an external contractor. A separate CR will be issued about the content and use of the Crosswalk once further progress has been made on its design and population. The Crosswalk will utilize NPI data from:

- The system which issues NPI numbers to providers;
- The PECOS database for provider enrollment in Medicare; and
- The legacy ID systems (UPIN, OSCAR, and NSC).

Expected Crosswalk Characteristics (subject to change as development proceeds)**:**

- Each NPI will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The Crosswalk should be able to search both from Medicare legacy identifiers to NPIs and from NPIs to legacy identifiers.
- The Medicare Crosswalk will be updated daily to reflect new provider registrations.
- There will not be a 1-to-1 relationship between every NPI and every Medicare legacy identifier. An NPI owner may have had multiple legacy identifiers, or an entity that previously had a single Medicare legacy identifier might obtain more than one NPI for subparts which can function as separate providers in their own right.

Impact of Stage 2 on EDI, DDE, and Paper Claim Transactions:

- X12 837 Incoming Claims and COB--During Stage 2, an X12 837 version 4010A1 electronic claim and other version 4010A1 electronic transactions may technically be submitted with provider NPIs only, but following the WEDI dual number strategy, carriers, DMERCs, and FIs will be directed to notify providers, clearinghouses and billing services to also submit the Medicare legacy identifier as a secondary identifier when they submit an NPI for any provider referenced in their inbound X12 837 EDI transactions. If only a legacy number is reported for one or more providers referenced in an incoming claim, only the legacy number of those providers will be reported in any issued COB claim. If an NPI is submitted for one or more of the providers referenced in a claim, but no legacy number(s), the Crosswalk must be searched to obtain the appropriate legacy number(s). If one or more of those NPIs cannot be located in the Crosswalk, the claim must be rejected as unable to identify the provider. If the NPIs are located in the Crosswalk, the legacy number for those providers, as well as their NPIs must be reported on any COB claims. The taxpayer identification number of the pay-to-provider must also be reported in a COB claim (in addition to the Medicare legacy identifier) when an NPI is reported on the inbound claim for that provider.

- DDE Screens--Medicare claim, eligibility and claim status DDE screens must be upgraded for Stage 2 as needed to enable a provider to submit either an NPI or a legacy identifier, or both between October 2006 and May 22, 2007. Effective May 23, 2007, the legacy identifier field would need to be "protected" to prevent entry of a legacy identifier. Neither type of provider identifier may be autofilled by the DDE system.

- Paper Claim Forms—Separate CRs will be issued once CMS obtains Office of Management and Budget Paperwork Reduction Act approval for Federal use of the revised CMS-1500 and the UB-04. Those CRs will discuss requirements for implementation of those forms, and termination of acceptance of the old forms.

- Free Billing Software—This software must be changed as needed by the beginning of Stage 2 to enable reporting of either a provider's legacy identifier or NPI, or both.

- X12 835s and SPRs—When an NPI is available in the data center provider file for the pay-to-provider, it will be inserted at the envelope (1000B) of the X12 835 and the legacy identifier and taxpayer identification number (TIN) will be furnished in separate REF segments in that loop. If no NPI is available, the pay-to-provider's TIN will be reported in the envelope and the provider's legacy identifier in a REF segment of that loop. The SPR will report only one identifier for the pay-to-provider and that will always be the NPI if it is in the data center provider file. If the NPI is not in the data center file, the legacy number will be reported in the SPR.

- X12 276/277—The Stage 1 rule will continue to apply during Stage 2.

- X12 270/271—If both the NPI and a legacy identifier are submitted on a 270, both will be included in the 271 response. If only the NPI is reported on the 270, it will be returned on the 271. If only a legacy number is reported on a 270, it will be returned on the 271 response.

- Claims History--Although the legacy identifier will continue to be used for Medicare processing for an indefinite period, both the NPI and the legacy identifier will be reported to claims history.

- Proprietary Error Reports—If these reports would have included a legacy identifier for a provider prior to October 2006, they must be able to report either the legacy identifier or the NPI, or both at the beginning of Stage 2. They must also be able to report NPI-related errors detected as result of editing or Crosswalk validation.

- The 835 PC-Print and Easy Print software must be modified by the beginning of Stage 2 to also enable either the NPI or a Medicare legacy number to be reported in the provider identifier field, but not both, following the same usage rule as applies to the SPR.

- Shared System Provider File—This must be expanded to report both an NPI and the corresponding Medicare legacy identifier for each provider by the beginning of Stage 2.

- Carrier, DMERC, and FI Local Provider Files—To the extent that these provider files included provider legacy identifiers prior to October 2006, they must be expanded to also include the NPI.

- Med A and Med B Translators—The translator to flat file maps and IG edit modules must be updated as needed to permit processing of transactions with an NPI.

Validation or Verification of NPIs during Stage 2

The Crosswalk should enable Medicare to validate most NPIs to:

- Make sure that they were actually issued to the providers for which reported, and
- Identify problems such as a transcription error in a reported NPI.

This validation shall be applied to NPIs whether received via DDE, EDI transaction, or on a paper claim, once the new forms are implemented. The X12 837 claim allows for reporting of multiple types of NPIs, e.g., billing provider, referring provider, rendering provider. More information is included in the 837 for some types of providers, such as a billing provider, than others. Where supplemental data is available for a particular provider type, such as provider name and zip code, it should be possible to match that data against data in the Crosswalk to establish a high level of certainty that a reported NPI was actually issued to that particular provider. Even when adequate supplemental data isn't available for a particular provider to enable that level of NPI validation against the Crosswalk, it will still be possible to verify that the structure of a submitted NPI complies with the NPI structure requirements. Validation will be discussed in greater detail in a separate CR once the Crosswalk is developed.

STAGE 3 involves acceptance and processing of transactions, except COB claims that Medicare sends to small trading partners, effective May 23, 2007, and later:

- HIPAA prohibits reporting of any provider legacy identifiers to other than small health plans (those with less than $5 million in annual receipts) during this period. Legacy identifiers will no longer be sent to COB trading partners, or on other outbound electronic or paper Medicare transactions or correspondence.
- By this time, all 837, NCPDP, DDE, paper claims, and free billing software claims, 270s, and 276s sent to Medicare must contain the NPI in lieu of legacy identifiers. Those transactions that do not contain an NPI to identify a provider are to be rejected. All outbound 835s, COBs, 271s, 277s, and SPRs should carry NPIs.
- Transition to full use of the NPI is to have been completed.
- NPI validation and verification editing is expected to continue as during Stage 2.

STAGE 4 involves transmission of 837 version 4010A1 COB claims to small trading partners effective May 23, 2007-May 22, 2008. Provider legacy identifiers will no longer be sent to small trading partners after May 22, 2008.

There are multiple segments and data elements where an NPI or other provider identifier can be reported in X12 transactions. An inventory of the segments and data elements involved in identification of providers in each of the transaction standards adopted under HIPAA, as well as when a secondary identifier can be reported for each location is attached (attachment 1) to assist Medicare contractors with programming of these business requirements.

C. Notes:

1. There are multiple references to changes that are to be effective on specific dates in this CR. The date of shared system processing of inbound (to Medicare) claims and other transactions, and the

date of shared system issuance of the outbound (from Medicare) flat file determines which requirements apply to individual paper, DDE, SPR, or EDI claims or transactions. For example, the date of service of an X12 837 version 4010A1 claim is December 22, 2005; Medicare received the claim late on December 31, 2005, but the shared system first processes that claim on January 3, 2006. The claim is submitted with the NPI and the Medicare legacy identifier. Even though received prior to the January 3, 2006 effective date for Medicare acceptance of NPIs, by the time first processed, the shared system release had been loaded allowing NPIs to be accepted. That December 31, 2005 claim may not be rejected due to the presence of an NPI.

The instruction to eventually be issued for Stage 3 will go into detail concerning issues such as what provider identifier to report in an 835 on May 23, 2007 or later when the 835 includes data on claims submitted before May 23, 2007 without an NPI; what to report in an 835 issued in response to a long-pending appeal or as result of a suit in Federal Court that involves claims that may have been submitted before issuance of NPIs began; and appropriate actions in regard to claims received May 22, 2007 with only legacy identifiers which may first be processed by a shared system on May 23, 2007 or later.

2. Many FIs conduct many implementation guide (IG) edits before they forward transaction data to their shared system, and some carriers use front end editors that apply certain IG edits prior to transmission of transactions to their shared system. Business Requirements for application of new NPI edits are listed in this CR as shared system responsibility only. From a standardization and cost perspective, that is the most efficient level at which to conduct these edits. The shared systems will conduct these edits upon receipt of transaction files from their users, but prior to passing of that data to the Core System for claim adjudication or other appropriate processing. Contractors that previously programmed for such an edit in their front end may continue to operate that edit at that level, but it should not be added to contractor front end editors if not already programmed.

3. The NPI implementation period coincides with establishment of the Durable Medicare Equipment Medicare Administrative Contractor Sites (DMACs), as well as with establishment of the requirements for the A/B MACs. Information has been entered in the Other column of these Business Requirements to identify those that do apply to the DMACs or the MACs.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

NOTE: *These business requirements are the same that appeared in transmittal 180/CR 4004 with the exception that the first 4 digits of these business requirements in that CR began with 4004.*

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4320.1	Carriers, DMERCs, and FIs with local front end editors, and shared system maintainers shall deactivate any edit(s) that would reject an 837 version 4010A1 claim with an XX qualifier in any NM108 data element, a 10-digit number in any NM109 data element, or would otherwise reject a transaction submitted with an NPI.	X	X	X	X	X	X	X		DMACs
4320.2	Shared systems shall reject as unable to identify the provider if an 837 version 4010A1 claim is submitted with an XX qualifier in an NM108 data element in any provider loop that does not contain a 10-byte numeric identifier in the immediately following NM109 data element. No special characters or letters may appear in that 10-digit number.					X	X	X		
4320.3	Shared systems shall reject as unable to identify the provider if an 837 version 4010A1 claim is submitted with an XX qualifier in an NM108 data element in any provider loop that does not contain a 1, 2, 3, or 4 as the first digit of the 10-digit number in NM109.					X	X	X		
4320.4	Shared systems shall reject as unable to identify the provider if an 837 version 4010A1 claim is submitted with an XX qualifier in a NM108 data element in any provider loop if the 10th digit of the number that follows in NM109 does not equal the number obtained using the formula in attachment 2.					X	X	X		
4320.5	FISS shall reject as unable to identify the provider if any 837 version 4010A1 claims are received with an XX qualifier in a NM108 data element in the 2010AA, 2010AB, 2310A, B, C, or E, or 2420A, B, or C loops which does not contain a REF01 with a 1C (Medicare provider number) or 1G (when the provider is a physician) qualifier in the same loop.					X				
4320.6	Shared systems shall edit to determine if any 276 transaction that contains an XX qualifier in NM108 of the 2100C loop and an NPI in NM109 has a second iteration of that loop					X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	which contains an SV qualifier in NM108 and the Medicare legacy identifier in NM109. Shared systems shall reject the transaction as unable to identify the provider during stage 1 if SV and the Medicare legacy identifier are not present when the NPI is reported.									
4320.6.1	Shared systems shall reject as unable to identify the provider if a 276 version 4010 (if supported for 276/277) or 4010A1 claim status request is submitted with an XX qualifier in the 2100C NM108 data element that does not contain a 10-byte numeric identifier in the following NM109 data element. No special characters or letters may appear in that 10-digit number.					X	X	X		
4320.6.2	Shared systems shall reject as unable to identify the provider if a 276 version 4010 (if supported for 276/277) or 4010A1 claim status request is submitted with an XX qualifier in the 2100C NM108 data element that does not contain a 1, 2, 3, or 4 as the first digit of the 10-digit number in that NM109.					X	X	X		
4320.6.3	Shared systems shall reject as unable to identify the provider if a 276 version 4010 (if supported for 276/277) or 4010A1 claim status request is submitted with an XX qualifier in the 2100C NM108 data element if the 10^{th} digit of the number that follows in NM109 does not equal the number obtained using the formula in attachment 2 of this CR.					X	X	X		
4320.6.4	Shared systems shall report both the NPI and the provider legacy identifier submitted in a 276 version 4010 (if supported for 276/277) or 4010A1 transaction in the 277 version 4010A1 response transaction issued.					X	X	X		
4320.6.5	Shared systems shall reject as non-compliant a 276 submitted with more than three iterations of the 2100C loop, or entry of the same qualifier (XX, SV or FI) more than once in NM108 of					X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	the 2100C loop iterations in a 276.									
4320.6.6	Shared systems shall reject as unable to identify the provider if a 276 version 4010 (if supported for 276/277) or 4010A1 is submitted with FI in NM108 of the 2100C loop and SV is not entered in NM108 of another iteration of the 2100C loop.									
4320.7	VMS and MCS shall reject as unable to identify the provider any 837 version 4010A1 claims with an XX qualifier in NM108 in the 2010AA, 2010AB, 2310A, B, C, D or E or 2420A, B, C, D, E or F loops which do not contain a REF01 with a 1C or 1G qualifier , as appropriate, in the same loops.						X	X		
4320.8	DMERCs shall notify submitters of NCPDP claims that they must continue to report their Medicare legacy identifier in those transactions and that reporting of an NPI in those transactions prior to October 2006 is likely to result in rejection of those transactions.				X					DMACs
4320.9	VMS shall reject NCPDP claims received with a Service Provider ID qualifier of 01 (NPI) in the Transaction Header service provider ID qualifier segment (202-B2).							X		
4320.10	Contractors shall notify claim status DDE screen users that they must continue to report their Medicare legacy identifiers in the claim status DDE screen, and that reporting of an NPI in this DDE screen prior to October 2006 will prevent identification of the claim for which status is requested.	X	X	X	X					DMACs MACs
4320.11	FIs shall notify DDE claim submitters that they must continue to report their Medicare legacy identifier for these claims, and that reporting of an NPI in a DDE claim prior to October 2006	X	X							MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	will prevent adjudication of their claims as Medicare will not yet be able to identify providers based on NPI.									
4320.12	Contractors shall include NPIs submitted on accepted claims in any 837 COB version 4010 or 4010A1 transactions issued in response to those claims. Shared systems shall include NPIs from an incoming claim in the flat file prepared for COB, and the carriers, DMERCs, and FIs shall include that information from the flat file when translating to an outbound 837 COB transaction.	X	X	X	X	X	X	X		DMACs MACs COBC
4320.13	Contractors shall notify submitters of the X12 270 version 3051 or of any other non-claim legacy electronic format transaction still being supported, and of the CMS-1500 (non-revised version) and of the UB-92 paper claims that they must continue to report Medicare provider legacy identifiers in those transaction formats and forms, and that Medicare will not be able to process those transactions if submitted with NPIs.	X	X	X						DMACs MACs
4320.14	DMERCs shall notify submitters of non-HIPAA format incoming electronic format transactions and of paper claims that they must continue to report their Medicare legacy ID in those transactions. Medicare is not yet able to process transactions based upon receipt of only an NPI.				X					DMAC
4320.15	Contractors shall notify COB trading partners that NPIs submitted on 837 version 4010A1 claims will be forwarded to those trading partners that accept 837 version 4010 (pending termination of the COB contingency plan if this version is being accepted by any COB trading partners) or 4010A1 COB transactions along with the Medicare legacy identifiers submitted	X	X	X	X					DMAC MACs COBC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	on those claims.									
4320.16	837 COB version 4010/4010A1 flat files shall be modified as necessary to be able to report NPIs as well as the legacy identifiers when NPIs are reported on inbound Medicare 837 claims.					X	X	X		COBC
4320.17	Shared systems shall reject as non-compliant with the implementation guide any 837 version 4010A1 claim that contains XX in NM108, the NPI in NM109, and 1C or 1G as applicable in REF01of the same loop, but which lacks another REF01 in the billing or pay-to-provider loop with the EI (Employer Identification Number) qualifier and number or the SY (SSN, applies to carriers & DMERCs only) qualifier and number to convey the taxpayer identifier.					X	X	X		
4320.18	VMS shall reject NCPDP claims as unable to identify the prescriber if received with a prescriber ID qualifier of 01 (NPI) in 466-EZ.							X		
4320.19	Carriers, DMERCs and FIs shall post information on their provider web site within two weeks of release of this CR and in a provider newsletter prior to January 2006 of the additional edits to be applied as result of this CR, other than those in business requirements 4004.3, 4004.4, 4004.6.2, and 4004.6.3, which are to be kept confidential. They shall notify claim and 276 submitters of actions they can take to avoid rejection of their transactions as result of these edits, or to correct and resubmit transactions rejected as result of these edits.	X	X	X	X					
4320.20	Shared system maintainers shall continue analysis of the NPI regulatory requirements and the impact of use of NPIs on the shared systems to determine the anticipated crosswalk data					X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	needs for transaction processing, and will participate in discussions with CMS and other contractors with a role in the crosswalk design for determination of the data elements for and use of that crosswalk.									

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4320.21	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	**X**	**X**	**X**	**X**					

V. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: CR 3892, Pub. 100-20 Transmittal 160; CR 4004, Pub. 100-20 Transmittals 172 and 180

X-Ref Requirement #	Instructions
3892.1-15	Systems Analysis, Planning and Initial Systems Changes Integral to the Implementation of the National Provider Identifier (NPI) Including Design Work in Preparation for the Definition, Construction and Ongoing Maintenance of a CMS Provider Crosswalk System

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

VI. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date: January 3, 2006** **Pre-Implementation Contact(s):** X12 837-P or CMS-1500 claims: Brian Reitz, 410.786.5001, Brian.Reitz@cms.hhs.gov X12 837-I, DDE, UB-92, or UB-04 claims: Matthew Klischer, 410-786-7488, Matthew.Klischer@cms.hhs.gov X12 835 and SPR: Sumita Sen, 410.786.5755, Sumita.Sen@cms.hhs.gov NCPDP Claims: Thomas Latella, 410.786.1310, Thomas.Latella@cms.hhs.gov X12 276/277 Transactions: Michael Cabral, 410.786.6168, Michael.Cabral@cms.hhs.gov	**Funding for Medicare contractors is available through the regular budget process for costs required for implementation.**

Post-Implementation Contact(s): Same as the Pre-Implementation contacts.	

***Unless otherwise specified, the effective date is the date of service.**

Attachments

ATTACHMENT 1

Locations of Provider Information in EDI Transactions

837 Institutional version 4010A1 Implementation Guide (IG)

2000A Billing/Pay-to-Provider PRV: Required if the Service Facility Provider is the same entity as the billing provider and/or the pay-to-provider. This applies to all subsequent claims in this hierarchical batch, except when loop 2310E is used. When used, ZZ must be reported in PRV02 and the taxonomy code in PRV03.

2010AA Billing Provider Name NM1: Required segment & loop
NM108=EIN, SSN or NPI qualifier
NM109=the applicable number
REF-Situational but required if necessary to report a secondary ID. Contains qualifiers for the legacy IDs (state license #, BC#, BS#, Medicare Provider #, Provider UPIN, Medicaid Provider #, Champus #, Facility ID #, PPO #, HMO #, Clinic #, Provider Commercial #, Provider Site #, Location #, State Industrial Accident Provider #, EIN, SSN). Two REF segments needed in the same loop if necessary to report both a legacy identifier and a tax ID.

2010AB Pay-to-Provider Name NM1: Required if the pay-to-provider is different than the billing provider.
NM108, NM109-same as in 2010AA
REF-same as in 2010AA

2300 CLM—Required segment and loop
CLM05=Health Care Service Location Information
CLM05-1=Facility Code Value
CLM05-2=Facility Code Qualifier (codes maintained by the NUBC; see the UB-92 instructions in Chapter 25 of the Medicare Claims Processing manual)
CR6 Situational but required for home health claims
CR617=Patient Location Code for the place where the services were supplied to the patient

2310A Attending Physician Name—Required for each inpatient claim or when a home health plan of treatment is needed
NM108, NM109=same as in 2010AA
PRV02—required to report taxonomy code
REF—same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN.

2310B Operating Physician Name—Required when any surgical procedure code is included in an inpatient or other claim or encounter, such as when a home health plan of treatment is required for adjudication.
NM108, NM109—same as in 2010AA
REF—same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310C Other Provider Name—Required for outpatient and home health claims to identify who rendered the care if rendered by a party other than the billing or pay-to-provider. Would apply if another provider temporarily furnished care while the primary provider was closed for a short period such as for vacation or for emergency repairs. Required for non-outpatient claims if the physician who rendered the service for the principal procedure on the claim is other than the operating physician.

NM108, NM109—same as in 2010AA
REF—same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310E Service Facility Name—required if the location of the service is other than the billing or pay-to-provider's location
NM108, NM109—same as in 2010AA
REF— same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

The following would only be included in an 837 I if there is a need to report an additional payer specific provider ID for a non-cob payer. NM108 is not used in these loops. The same NM1 and REF information in 2330D applies to each of these segments.

2330D Other Payer Attending Provider—
REF—same as in 2010AA. There is no NPI qualifier.

2330E Other Payer Operating Provider

2330F Other Payer Other Provider

2330H Other Payer Service Facility Provider

The following would only be included if needed to identify where the provider for a specific service differed from the provider information for the rest of the claim.

2420A Attending Physician Name
NM108, NM109—same as in 2010AA
REF—same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2420B Operating Physician Name
NM108, NM109—same as in 2010AA
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2420C Other Provider Name—Required if outpatient or home health care is involved and a substitute provider furnished the service on this line only, or if non-outpatient but the physician who rendered this service, NM109-- same as in 2010AA
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

837 Professional version 4010A1 IG

2000A Billing/Pay-to-Provider Specialty Information –Required if the rendering provider is the same as the billing or pay-to-provider.
PRV—required when adjudication is known to be impacted by the provider taxonomy code and the rendering provider is the same as the Billing and/or Pay-to-Provider.

2010AA Billing Provider Name—required
NM108, NM109=EIN, SSN, NPI qualifiers (no PRV in this loop)
REF—full list of secondary qualifiers

2010AB Pay-to-Provider Name—Required if different than the billing provider
NM108, NM109-- same as in 2010AA
REF—full list of secondary qualifiers

2310A Referring Provider Name—Required if the claim involved a referral

NM108, NM109- same as in 2010AA
PRV—only required if specified in the provider-payer contract
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310B Rendering Provider Name—Required if different than the billing or pay-to-provider name
NM108, NM109-- same as in 2010AA
PRV—Required to report taxonomy code
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310C Purchased Service Provider Name—Required if the claim involves purchased services such as a diagnostic examination obtained from a third party
NM108, NM109-- same as in 2010AA (no PRV in this loop)
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310D Service Facility Location—Required if the place where the health care was rendered is different than the location of the billing or pay-to-provider, or if the service qualifies for a HPSA bonus
NM108, NM109-- same as in 2010AA (no PRV in this loop)
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2310E Supervising Provider Name—Required if the rendering provider was supervised by a physician
NM108, NM109-- same as in 2010AA (no PRV in this loop)
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

The following would only be included in an 837 P if there is a need to report an additional payer specific provider ID for a non-cob payer. NM108 is not used and there is no PRV segment in these loops.

2330D Other Payer Referring Provider
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN (not possible to report NPI in this segment)

2330E Other Payer Rendering Provider—same as in 2330D

2330F Other Payer Purchased Service Provider—same as in 2330D

2330G Other Payer Service Facility Location—same as in 2330D

2330H Other Payer Supervision Provider—same as in 2330D

The following would only be included if needed to identify where the provider for a specific service differed from the provider information for the rest of the claim.

2400 CLIA Identification—Required if claim includes lab services and some of those services were referred to an external lab for processing, that lab is also CLIA certified, and the cost of the services provider by that lab are included in this claim.
REF02=CLIA number.

2420A Rendering Provider Name
NM108, NM109-- same as in 2010AA
PRV—required to report taxonomy code
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2420B Purchased Service Provider

NM108, NM109-- same as in 2010AA (no PRV segment in this loop)
REF-- same as in 2010AA but there would not be a second REF segment for reporting of the EIN or an SSN

2420C Service Facility Location—same as 2420B
2420D Supervising Provider Name—same as 2420B
2420E Ordering Provider Name—same as 2420B
2420F Referring Provider Name—same as 2420A (includes a PRV segment)

835 version 4010A1 IG

1000B Payee ID—Required
N103—TIN and NPI qualifiers
REF—full list as in the 837 IGs for secondary qualifiers

2100 Service Provider Name—Required if the rendering provider if other than the payee. Information on other providers reported in a claim is not included in an 835 since those other providers are not parties to the payment issued with an 835.

2110 Rendering Provider Information—Required if the rendering provider for the service in this loop is different that the payee or the service provider.
REF01=NPI as well as the full list of secondary qualifiers permitted in the 837 provider REF segments.

276/277 version 4010A1

2100C Provider Name—Required (used the same in both the 276 and 277); repeat the loop to report more than one provider identifier
NM 108, NM109=TIN, legacy number, NPI qualifiers

NCPDP

Transaction Header Segment
201-B1 Service Provider ID—Required. Allows an NSC # or an NPI to be reported, but only one or the other may be reported.

Prescriber Segment
466-EZ Prescriber ID Qualifier—Required. Contains qualifiers for UPIN or NPI, but only one may be reported.
411-DB Prescriber ID—Required. Contains the UPIN at present and will be used to report the NPI, but only one may be reported.

ATTACHMENT 2

NPI Validation Routine

The NPI validation is done as follows:

1) For the purposes of this validation routine, isolate the last digit of the NPI and do not use it in any steps outlined below;
2) Precede the NPI with 80840;
3) Double the value of alternate digits, beginning with the rightmost digit, remember that the check digit is not to be used;
4) Total the value of the individual digits from step #3;
5) Total the value of the unaffected digits;
6) Add the two sums from steps #4 and #5;
7) Take the sum of step #6 and go to the next higher number ending in zero;
8) Subtract the sum of step #6 from the next higher number ending in zero from step #7;
9) If the value in step #8 matches the last digit in the submitted NPI, the NPI is valid.

Example of Check Digit Validation of the NPI

The NPI submitted is 1234567893. The NPI validation is done as follows:

1) For the purposes of this validation routine, isolate the last digit of the NPI (3) and do not use it in any steps outlined below;
2) Precede the NPI with 80840 (8 0 8 4 0 1 2 3 4 5 6 7 8 9 3);
3) Double the value of alternate digits, beginning with the rightmost digit, remember that the check digit is not to be used (0 8 2 6 10 14 18);
4) Total the value of the individual digits from step #3 (0+8+2+6+1+0+1+4+1+8) which equals 31;
5) Total the value of the unaffected digits (8+6+4+2+0+8+8) which equals 36;
6) Add the two sums from steps #4 and #5 (31+36) which equals 67;
7) Take the sum of step #6 and go to the next higher number ending in zero which is 70;
8) Subtract the sum of step #6 from the next higher number ending in zero from step #7 (70-67) and the value is 3;
9) The value in step #8 matches the last digit in the submitted NPI, therefore the NPI is valid.