CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: David Clark
September 26, 2006
1:00 pm CT

Operator: Good afternoon. My name is (Regina) and I will be your conference operator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services National Provider Identifier Round Table.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question press the pound key.

Thank you. Mr. David Clark you may begin your conference.

David Clark: Thank you very much. Good afternoon everyone and welcome to the 21st HIPAA Round Table conference call. And this is actually the second round table that has been dedicated to NPI, the National Provider Identifier Round Table.

I really appreciate you taking time with us this afternoon. We are hoping and looking forward to a very productive session this afternoon. We hope to address as many of your questions as we possibly can.

I know that those that have been on the other calls have been working with Dr. Bernice Harper, and I'm sure she's established herself as something as a legend with these calls, but I won't even try to measure up to the shoes that she has set forth. But I do hope that we have a productive session this afternoon.

I will go through the agenda and some of the expectations for today's call after opening remarks from (Gerri) Nicholson, the Director of the Provider Communications Group here in the Centers for Medicare and Medicaid Services.

Geraldine Nicholson: Great. Welcome everyone. We have a good turn out today. That's good news because we have eight months left before the compliance date for use of the NPI on healthcare claims.

I'm the chairperson at CMS for NPI outreach and I want to assure you that we're using every tool in our arsenal of outreach methods to make sure the providers understand NPI and make sure they get their NPI and are ready to use it.

We're using our FIs and carriers and our Regional Offices, our Medicare Advantage plans, our prescription drug plans, our press office, our Medicaid state agencies, our state survey agencies, our QIOs, plus we're reaching out to the national and local provider associations and organizations for them to tell their membership about NPI.

And we've also been collaborating on the private side with WEDI and through WEDI with the American Health Insurance Plans and the Blue Cross and Blue Shield Association to make sure we're getting a good comprehensive message out to the provider community. All this effort makes sure that every healthcare provider knows about NPI and that they get it, share it and use it.

For this round table we solicited a number of questions from the public and we looked at those questions, triaged them and essentially have about four different categories of questions that we've asked subject matter experts to address in their presentations.

The kinds of questions that we got had to do with parts and subparts, data dissemination, taxonomy and some Medicare claims processing questions.

In terms of the taxonomy, Medicare did recently post a frequently asked questions (FAQ)on the CMS Web site that answered a lot of the questions that came in about taxonomy. And I'll give you the beginning of that answer, but you can go to the Web site and look at the entire question and answer.

And essentially only institutional providers that currently bill Medicare using more than one legacy identifier, or OSCAR, in order to identify subparts of their facility are required to submit a taxonomy code on all claims they submit to Medicare.

So that frequently asked question is on the CMS.gov Web site. You can go there and click on questions and type in NPI and you'll be able to see that.

Speaking of Web sites, we have a dedicated Web site where we have all the information that providers need to know about NPI. We have a section that is

relevant for all providers across the country and then we have a special section for the Medicare provider community.

So with that we want to get started and get to the heart of this meeting. I'm going to turn it back over to David at this time. And thank you all again for attending.

David Clark: Thank you (Gerri). Today's agenda includes three topics that we're going to be covering, the data transmission, subparts and Medicare implementation. The format for today's call that we'll go through each of the topics first and then we'll open up the lines for questions and answers.

And that sort of segues me into my role. I was asked to strike a balance if you will between an open dialogue but at the same time optimizing the limited time that we have for Qs and As on this call.

So I would appreciate it if when you're making your question or comments that they be concise and specific with your questions. This call is not for individual case work, that if we get - see ourselves getting bogged down into a very esoteric piece of the rule in looking at a very specific technical issue that applies to some of the providers in the facility, I will interrupt and ask that we try to handle that offline, ask for some contact information from you, so that we can follow with you later.

The - once the line is opened up that where you've indicated by pressing the pound that you want to speak, please speak up so that we can get through as many questions as we possibly can. There will be a transcript of this call and it will be posted on the Web site immediately after.

At this point I'd like to turn the speaker over to the - the speakerphone over to Pat Peyton. She'll be discussing data dissemination and subparts.

Patricia Peyton: Good afternoon. I'm Pat Peyton from the Office of Financial Management here in CMS. And my presentation today will attempt to answer the questions that we received in advance of the round table that related to data dissemination and subparts. First, data dissemination.

The questions received in advance of today's round table related to the manner in which we will making NPPES -- N-P-P-E-S -- information available to the industry.

Examples of the questions I received: Will I be able to look up a provider's NPI; what if I don't know a doctor's NPI, may I ask him for it; will there be an NPI directory; when will the Data Dissemination Notice be published; and so forth.

Anyone who needs to know a provider's NPI for purposes of using it in a HIPAA standard transaction can ask the provider. If the provider is a covered provider, the provider must disclose its NPI, if requested, so it can be used to identify that provider in HIPAA standard transactions

The other questions related directly to the policy we are developing, and which is the core of the Data Dissemination Notice that is in clearance within HHS. Because the Data Dissemination Notice is still in clearance, we are not permitted to describe the policy to you, as it could be revised or fine tuned anywhere in that clearance process. We do hope to publish the notice very soon.

Now on to subparts. [Sorry] I'm going to discuss the subpart concept as it is described in the NPI final role and talk about that concept as it applies to the enrolled Medicare providers. This presentation also attempts to answer all the advanced questions that we received about subparts.

Nearly all of those questions dealt with specific situations and requested CMS advice on whether or not the described subparts needed their own NPIs. Short of what is in my presentation today, HHS, CMS and health plans really can't tell the providers how to enumerate their subparts.

This is an important business decision that they must make based on their own business needs in concert with the information in the final rules. We can help with the analyses but we're not permitted to tell the providers what to do.

The Final Rule places requirements on health plans, health care clearing houses and those health care providers who transmit any health information in electronic form in connection with any of the HIPAA standard transactions, even if the provider uses a billing service or a clearing house to do it.

We call these entities covered entities and we specifically refer to the healthcare providers as covered health care providers.

All HIPAA covered entities, the ones I just mentioned, and providers, whether they are organizations or individuals, are legal entities. It is possible that an organization health care provider that is a covered entity such as hospital, multi-specialty clinic and so forth, might be composed of components that furnish health care that operate within or at the same address as a covered health care provider or even at a separate location.

These components function as health care providers but they are not legal entities. They are part of the covered health care provider which is a legal entity and which we sometimes call the parent - and which I'm going to call the parent because it's a lot less words.

These components cannot be people such as physicians or dentists, because a person is a legal entity and these components are not. The Final Rule refers to them as subparts so as not to confuse them with the health care component concept that is tied to the HIPAA Privacy and Security Rules.

The NPI Final Rule gives examples of what could be considered subparts: Hospital units (such as psych and rehab units); members of chains of providers (such as the different locations of DME supplier or pharmacy chain members); components of organization health care providers that are required to have State certification or licensure separate from that of the parent (such as hospital laboratories and radiology departments); separate physical locations of covered organization health care providers (such as home health agencies and clinics).

The Final Rule makes it possible by introducing the subpart concept for subparts to have their own unique NPI if their parents deem it necessary. The Final Rule adds two criteria that parents must follow in considering the enumeration of their subparts.

Number one, if any subpart conducts any of the HIPAA standard transactions for itself regardless of whether it uses a billing service or a clearinghouse to do so, that subpart must have its own NPI.

For example, if the members of a chain of nursing homes each send their own HIPAA standard claims to health plans or check eligibility by using the

HIPAA standard eligibility transaction, then these subparts must have their own unique NPIs. They will use those NPIs to identify themselves as the providers in those HIPAA standard transactions.

Number two, if there are federal regulations that require the unique identification of a health care provider that is enrolled in a federal health program for the purpose of sending claims to that health plan, then that health care provider must have its own NPI because NPIs will replace today's billing numbers. Sometimes these health care providers are subparts.

To help clarify the issue of subparts for Medicare's enrolled organization providers, Medicare, the health plan, prepared a paper entitled, “Medicare Expectations for Subpart Determination”. This paper was posted on the CMS NPI Web page, the one that (Gerry) mentioned earlier, in February 2006 and was distributed widely by CMS.

This paper repeats the Final Rule’s messages concerning subparts. It notes that there are federal Medicare regulations that require each location of a Medicare DME supplier to have its own billing number.

Therefore, each location of a Medicare DME supplier must have its own unique NPI. Whether the headquarters (the parent) obtains the NPI for its subparts or whether the parent instructs each location to obtain its own does not matter as long as every location gets its own unique NPI. There are no similar federal regulations that relate to any other type of enrolled Medicare provider.

You should note though, that a DME supplier that is a sole proprietor who has more than one location is eligible for only one NPI just like any other health care provider who is an individual.

Number three, the paper explains that Medicare payments must by law be made only to enrolled Medicare providers. Medicare providers need to be sure that the Pay-to Provider is enrolled in Medicare. Thus the NPI of the Pay-to Provider must be known quote, unquote, to Medicare in order for the provider to be paid.

Medicare is building a crosswalk that is going to help ensure the identification of the Medicare providers when they are using their NPIs. The Medicare subpart paper does not change Medicare provider enrollment requirements, policies or procedures. It deals only with the subpart concepts.

Those are the basics of subparts. Here is some additional information to address the other subpart questions that we received before the round table.

Health plans should not be telling the health care providers to obtain or not obtain NPI for subparts in a manner that is inconsistent with the NPI Final Rule. Health plans are not permitted to require a health care provider that already has an NPI to obtain another NPI for any reason.

So if a clinic with three locations has decided to get just one NPI, and has done so in accordance with the information in the Final Rule (which is very important) the health plan cannot require that clinic to obtain an NPI for its other two locations.

One organization health care provider indicated that it is required by a contract with a health plan to follow the health plan's companion guide, which is a trading partner agreement.

If the health care provider follows that guide, it will be required to get NPIs for subparts in a way that it did not choose and therefore in a way that is not consistent with the Final Rule's requirement that the parents make the decision.

The HIPAA regulations prohibit a companion guide from changing the implementation specifications of any HIPAA standard. And the NPI is a standard and has its own implementation specifications which cannot be changed by a contract or a trading partner agreement.

Another health care provider said it is a hybrid entity, that only parts of it furnish health care. These parts are locations that are separate from the headquarters.

The headquarters does not furnish health care and never conducts HIPAA standard transactions but the separate locations do. Does the headquarters need an NPI?

First of all, the hybrid entity concept applies only to the Privacy and Security rules, not the NPI Final Rule. You won't see where that concept was discussed in the NPI Final Rule.

In the situation presented in the question, the headquarters represents the legal entity or the parent or the covered health care provider and, as such, it is required to have an NPI.

The two subparts must also have NPIs because they conduct HIPAA standard transactions. In reality, the headquarters will have no use today for its NPI, but that could change at any time in the future.

We also received--at least in the pile of questions that I was sent--a number of more general NPI questions. I think it's important to address them so that other people on the round table who don't have a general understanding can also benefit from the answers.

Does a provider need an NPI for Medicare, a different NPI for Medicaid, a different one for Blue Shield and so forth? The answer is no. One of the benefits of the NPI is that a provider's same NPI is used in all HIPAA standard transactions that need to identify that particular provider regardless of the health plan involved.

Another question. We have a group practice with ten physicians. Who gets the NPI, the group or the physicians? If the group conducts any of the HIPAA standard transactions it's a covered healthcare provider and as such must obtain an NPI. The ten physicians, on the other hand, are furnishing services at the group office or offices but they are not conducting any of the HIPAA standard transactions. The group is sending the claim. The group is checking eligibility and checking claim status, not the physicians.

If the group does these things electronically then it's a covered health care provider and must obtain an NPI. The physicians would not be covered health care providers and are not required by the NPI Final Rule to obtain NPI. But you might want to keep in mind, the group as the provider could require these physicians to obtain NPIs and use the NPIs to identify them as the rendering providers in the claims that the group submits.

Medicare is requiring all of its enrolled providers to obtain NPIs so if any of the physicians are enrolled in Medicare they will need NPIs if they don't already have them.

If any of them are planning to enroll in Medicare they'll have to have their NPIs in order to have their enrollment applications processed. And it's possible that other health plans could also require these physicians to get NPIs.

Someone asked if health plans can require the recording of the State license number to identify a physician as a health care provider in a claim instead of the physician's NPI. If the physician has an NPI, the NPI is to be reported to identify him or her as a health care provider in a HIPAA standard claims transaction.

While the license number might be a choice given as a secondary identifier in an X12 claims transaction's Implementation Guide, the NPI--if the provider has one--must be used as the primary identifier in that transaction, and when the NPI is used as the primary identifier, no secondary identifier is to be reported. And we do have an FAQ about - that I do believe covers this issue.

A sole proprietor optometrist with two different offices and two Medicare legacy identifiers, one for each office, has been having his checks come to the office where the service was rendered; that is, both office locations were able to receive checks from Medicare. He realizes that as a sole proprietor he can have only one NPI. He asks if this process would be affected by the NPI.

Well, the answer is that it probably will. We encourage this provider to have his checks sent via electronic funds transfer or EFT. The checks will go to one place, they will get there safely and it will ensure continuity of payment especially if coordination of benefits is involved.

Dr. Jones is a physician who sees patients and also is enrolled in a health plan as a DME supplier. How many NPIs does Dr. Jones get? The answer is one.

He is an individual who therefore can have only one NPI. He or the group that employs him will use that single NPI to identify Dr. Jones as a physician rendering medical services to patients and as a provider who furnishes DME.

What happens to UPINs? UPINs are continuing to be assigned to certain Medicare provider types for use in identifying them as ordering or referring providers in Medicare claims, but all this will end by May 22, 2007. Starting May 23 and thereafter, UPINS may not be used to identify providers in Medicare claims and the UPIN registry will be phased out.

This concludes my presentation, in which I tried to cover as many of the questions that I received as I could. You'll be able to ask some later.

David Clark: Great, thank you Pat. Just a reminder for the participants on the line, we're going to go through all of the presentations first so I would encourage you to jot down your questions or comments and set them aside. We will open up the mic shortly for Qs and As.

The next topic that we're going to cover is Medicare implementation, first by (Kathy Simmons) and then by (Sandra Grimmis). Kathy?

(Kathy Simmons): Hello. I am (Kathy Simmons) and I'm with the Office of Information Services here at CMS.

We received quite a few questions about how to record the NPIs when providers get them, either on paper claims or on electronic claims.

I'm going to be going through that, but since this involves quite a few different fields and loops and things like that, I just want to refer you to some

instructions that are available through the CMS Web site where this information is also available.

And plus that, if you don't know about this location it is probably worthwhile to have anyways, because actually all of the instructions issued by CMS are posted here.

That Web site is www.cms.hhs.gov/manuals. That's M-A-N-U-A-L-S. And when you get to that page, it will give you a choice of either looking at existing manuals or instructions that have been issued that will be going into existing manuals but are not effective yet.

Most of the instructions that deal with the NPI are not effective yet so you'd want to check on that future menu item and then you'll be presented with a list of all of the change requests, CRs that we've issued probably in the last year and that page will have a number for each.

I'll give you the numbers that apply to the paper claims. The number for the CMS 1500s that has just been revised to allow reporting of NPIs is CR 5060.

That's going to be effective in January. And the instruction for the UB04 paper claim that is not effective yet but will be effective in March for recording of NPIs is CR 5072.

There are also instructions that deal mostly with the electronic claim requirements for the different stages of Medicare's NPI implementation, those are CRs 4023, 4320, 5081 and 5229. And as always for the X12 transactions particularly, you should refer to the implementation guides for particular NPI requirements.

Our Medicare instructions address different things that are Medicare specific but still agree with the implementation guide, which is the primary authority for EDI format requirements.

With that said, I just want to get to some of these questions. Now there seems to be a lot of confusion about the 1500s, the revised 1500 form and the UB04 form.

Fifteen hundreds are for professional bills that would be physician bill, lab bills (independent labs, not hospital-based labs), things of that nature. And the UB04 is for institutional type claims such as hospital claims, skilled nursing facility claims, ESRD (most ESRD claims), home health claims for the most part, and things of that nature.

I think some of the confusion exists because the current forms that are used in both of these cases, the 1500 and the UB92 form--neither one of them was designed for use of NPI numbers, so there are no fields on either of them in which you can place NPIs.

That's why when we started to issue NPI instructions we said that NPI should never be reported on those quote, old forms, that NPIs are not to be recorded until a provider begins to submit the new forms.

So with that said, let's see, the first question. It had to do with where would the information about the NPI number of a billing provider go on a new 1500 form?

Well that form has been reorganized somewhat to be able to make space to record NPIs, but the billing provider information, and this could apply to either the individual physician who may be billing for themselves or a group

that's billing on behalf of an individual physician or other type of medical provider, the billing provider information goes into Box 33 of the 1500.

And if you have the NPI, which is still optional actually through May 22, although we encourage people to use it as soon as they get it, that NPI would go into Box 33A for the billing provider.

And to continue to report your legacy Medicare identifier, this might be a PIN or a UPIN in the case of a physician or an NSFC number for a 1500, that would go into Box 33B.

Now to differentiate what type of legacy identifier is going into Box 33B, the NUCC, the National Uniform Claim Committee, designed that box so you would first record a qualifier to indicate what type of number it is, followed by a space and then the legacy number.

The qualifiers themselves actually come from the X12 implementation guides. The 837 professional guide has a list of the qualifiers. The one that would apply to Medicare most often would be 1C, which stands for Medicare issued identifier.

Now people also asked where referring or ordering physician information would go on a 1500 form. Item 17 is the section that now refers to referring or ordering physicians on a 1500. 17A is for reporting of the UPIN of the referring or ordering physician and 17B would be used for recording of the NPI of a referring ordering physician.

There are also - I think Pat mentioned to you that if there is a rendering physician he or she should also be enrolled in Medicare--and rendering physician information goes into Box 24J.

And in each of these new boxes, these areas, there will always be two fields, one for the NPI, which actually says NPI in the box, and the other field is a shaded field used to report a legacy number.

Those shaded fields are to be used through May 22, 2007 to record the legacy numbers with a qualifier. From May 23, 2007 and on, you would not record anything in those shaded boxes.

There is another field on the 1500s for providers and that is for service facility providers. That's to identify a place of service if it was other than the physician's office or the patient's home. And that goes into box 32 with the NPI in Box 32A and the legacy number in Box 32B.

All of this information I've just gone over would be in that change request CR 5060 that you can obtain on the Medicare Web site. There is also information about paper claims - 1500 professional paper claims--in Chapter 26 of the Medicare claims manual, which you can also access at that same Web site.

I mentioned that you have a choice of the manual, current manual or future transmittal on the Web. If you were to check on current manual it would ask which one you want. The Medicare instruction is in the manual with the number 100-04. And then it lists all of the chapters in that particular manual. Chapter 26 has information on the 1500 form.

Besides the 1500 form, there are also some questions about the NCPDP form and electronic billing. The NCPDP format is an electronic format and it's only used by retail druggists that are billing Medicare for prescription drugs.

That particular format isn't quite as large as the other electronic formats and actually only has space to report one identification number for the retail pharmacy that fills a prescription and one identification number for the physician or practitioner who wrote the prescription in the first place.

So since there is only one field, it is not possible to report both an NPI and a legacy identifier. The provider, the retail pharmacy that would be submitting the claim, has to choose which one they want to record. It's one or the other, not both.

So through May 22, 2007, they can still record their current NSC number, national supplier number, and the UPIN for the prescribing physician, or they can report the NPIs there. Come May 23, 2007, the NPI is going to have to be recorded for both the retail pharmacy and the prescribing physician.

The retail pharmacy's NPI number would go into the 201-B1 field which is titled service provider ID. And the prescribing physician's number would go into the 411-DB field which is titled prescriber ID field. And there is a qualifier that would be recorded for each of those fields. This qualifier would identify the type of ID being recorded in that particular field. If it is a Medicare number or if it's an NPI, the qualifier would help to indicate that.

And that is very important, because the NSC numbers issued to retail pharmacies in the past were also ten digits. So without that qualifier it's going to be very difficult to determine which one is for an NPI and which one isn't.

Now as far as the electronic claims go one of these CRs that I mentioned - change requests that I mentioned, CR 5229 that you can get from the Web, has an attachment. Attachment 1 to that instruction has a summary of all the implementation guides that have been adopted under HIPAA and each of the

field segments, data elements, and loops in those transactions that would be used not only to record NPI information but also to record other information about providers, such as taxonomy code, name and address of providers, information that applies to providers in general. So I would encourage you to look at that particular attachment. Again that is Change Request 5229.

But just to run down the list quickly for the professional claims, the billing provider loop is 2010AA, the pay to provider loop is 2010AB, the referring provider loop is 2310A, the rendering provider loop is 2310B, the purchase service provider loop is 2310C, the service facility loop is 2310D and the supervising provider loop is 2310E.

Some of these types of providers can also have information reported in a service level loop. For instance, if the rendering provider reported at the claim level did not actually render all of the services on the claim, and if there was one service that was rendered by another provider, you would be able to record that information in a service level loop.

2420A is the rendering provider service loop; 2420B, the purchased service provider service loop; 2420C, the service facility provider service loop; 2420D, the supervising provider service loop; 2420E, the ordering provider service loop, and 2420F is the referring provider service loop. An ordering provider can be recorded at the service level but not at the claim level.

And in each one of these loops if an NPI is being recorded, it would always go into the NM109 data element and qualifier XX would go into the NM108 data element.

Now if a particular provider doesn't have an NPI yet, the person preparing the claim would continue to report the taxpayer identification number--either the EIN or the social security number—of a provider in the NM109 data element.

To continue to report an old identifier prior to May 23, 2007, there is also a reference segment, REF, in each one of these provider loops. Legacy numbers, such as a UPIN or NSC number, would be reported in the REF segments.

It's pretty similar on the 837-I claim, the institutional claim. There the billing provider information would also go into 2010AA, 2010AB would be used for information on a different pay-to provider, 2310A for the attending physician, 2310B for the operating physician, 2310C if there is an other provider and 2310E for a service facility provider.

There are also a few service level provider segments for institutional claims, 2420A is used to report information for an attending physician, 2420B for an operating physician and 2420C for an other type of provider.

In each of those loops, just like with the professional claim, the NPIs go into NM109, the qualifier into the NM108 data element and a legacy identifier into the REF segment.

So that's basically it. I'd encourage you to obtain the changed requests I mentioned on the CMS web page.

(Sandra Grimmis: My name is (Sandra Grimmis). I'm from the Office of Information Services. I'm going to do some other questions that were sent to the email box.

We were asked how will Medicare identify which locality the services were rendered in for payments. And our answer is group facilities and individual providers must obtain an NPI to bill Medicare. Medicare will require an NPI only on all claims received effective 5-23-2007 but we'll continue to process claims using the legacy number. Our claims systems have a crosswalk that Medicare will use to determine the legacy identifier that applies to each claim fro those providers that have more than one legacy ID. Locality is associated to the legacy number.

We were also asked where does the NPI go on the Medicare Part A, DDE screen for claims. Those screens are in the process of being modified and should be modified effective October 2 to enable recording of both the NPI and the legacy identifier. The fiscal intermediaries should issue information about this prior to October 2 if they haven't already done it.

We were also asked can providers continue to submit the UPIN for referring ordering providers when the referring ordering provider's NPI is not known. Yes, you can through 5-22 of 2007, but from 5-23-2007 on a UPIN cannot be reported. You must submit your referring provider's NPI.

CMS was also questioned about provider costs to upgrade their billing software and the cost to do so. Medicare cannot provide funding to upgrade a provider's billing software but Medicare does have a free billing software that will accept NPIs and is HIPAA compliant. You can contact your local carrier for more information on their free billing software.

David Clark: Okay, thank you very much. At this time we'd like to open up the mic for questions. Operator, can you assist me with that please?

And while she is coming, just a couple of comments. Again to remind you, we'd like for you to make your comments, to make them - sure that they're concise and the questions that you raise, they should be specific.

This is not an opportunity to do case work. We don't want to get bogged down in very lengthy technical questions that are specific to a provider. We do want to clarify policy and operational procedures that will help you through this.

Operator?

Operator: Yes sir. At this time I would like to remind everyone if you would like to ask a question, press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

David Clark: And also once your line is open, please identify yourself and the organization that you're with.

Operator: Your first question comes from (Karen Jadak).

David Clark: Hi (Karen).

(Karen Jadak): Hello. I'm calling from Fox Chase Cancer Center in Philadelphia. And our question relates to the NPI. Is that going to be a mandatory field for referring physician and what do we do in the case of referring physicians who are from out of the country, or if the patient is self referred?

Kathy Simmons: An NPI is not required for a foreign physician who orders a service, attends a patient, or refers a patient for tests or treatment on a claim. Actually if a U.S. provider is not a HIPAA covered entity, the provider is not required to obtain an NPI. Since there are few providers that would never bill some insurer or

submit a HIPAA format eligibility request, even if a U.S. provider did not normally treat Medicare patients, the provider would most likely have needed to obtain an NPI to interact with some insurance company.

(Karen Jadak): It says that the referring physician field can be blank.

Kathy Simmons: Well if that's what the implementation guide says you must be looking at the 837 professional implementation guide. It does say that the EIN, the SSN or the NPI of a referring provider is to be recorded “if known”.

(Karen Jadak): Okay, thank you.

Operator: Your next question comes from (Xena Jacobi).

David Clark: Hi (Xena).

(Xena Jacobi): Hi, thank you. This is (Xena Jacobi) from (Appria) Healthcare. And we are a large DME and infusion supplier. And while I understand that the health plans cannot define how we enumerate, we do consider that it's in our interest to be enumerating in a process that's going to work well with them so that our billing is going to - will continue as normal come the compliance date.

And so for - on the Medicare side, we understand that we do need an NPI for each of our physical locations. And we do have other payers that would prefer that we have separate NPIs for our infusion versus our DME business.

So I'm wondering if we would be able to enumerate to - for each of our physical locations to actually get an NPI both for - one for the DME and one for the infusion business.

Pat Peyton: There are different taxonomy codes. You could do that if that's that you wanted to do.

(Xena Jacobi): And so there wouldn't be any problem on our Medicare claims to do it that way? So on our Medicare claims we would be going from one current Medicare supplier number to two NPIs, one for DME and one for infusion?

(Kathy Simmons): The only thing I would recommend to you is since you're going from one number to two numbers is that you update your Medicare enrollment record to show that you're going to be using the two NPIs. Pat , would they use the 855 form to do that? Can they get that form off the Web?

(Jim Bossenmeyer): You need to include that information on your NPI application. Certainly if you have not enrolled or if you're making a change in enrollment for Medicare with the National Supplier Clearinghouse, then you want to make sure that you provide that information to them.

It's not necessary to submit information regarding your NPI to the - either a carrier or fiscal intermediary or the National Supplier Clearinghouse for an NPI change. Clearly if you are dually enrolling and making a change, then that information will be required.

(Xena Jacobi): I'm not sure that I understood that. Was that in terms of the 588 form?

(Jim Bossenmeyer): No, the 588 is for electronic funds transfer. The 855 is…

(Xena Jacobi): Oh okay, sorry.

(Jim Bossenmeyer): The Medicare application for enrollment purposes. If you are - you should update your NPPES information to reflect the billing numbers that you'll be using associated with that NPI number. That's the first step.

If you're making a change to existing Medicare enrollment, then you should then report that information as part of that change. So if you're opening up a new practice location, there is a change in ownership, those types of activities that are identified as part of a normal change, then you would send that information to the Medicare contractor, whether it be a fiscal intermediary or, in this case, the national supplier clearinghouse.

(Xena Jacobi): So if there is no change to a location, and it's currently doing infusion and DME, then we wouldn't have to change our Medicare enrollment but we could go ahead and apply for two NPIs?

(Jim Bossmeyer): Yes, and apply for two NPIs.

Patricia Peyton: And this is Pat Peyton. And what (Jim) said is when you apply for those NPIs, put your Medicare legacy numbers in the “other provider identification number” part of the NPI application form.

(Xena Jacobi): Oh okay, right. Okay. One other question.

David Clark: I'm sorry Xena. Can - I'll need to move on for another caller please.

(Xena Jacobi): Okay, thank you very much.

David Clark: Certainly. Operator, our next call.

Operator: Your next - yes your next question comes from (Gail Hyslop).

(Gail Hyslop): Yeah, this is Gail Hyslop) with (Fiserve) Health. And we're a large third party administrator. And there is a provision in the Final Rule in the comment response section which indicates that health plans are not prevented from requiring paper - NPI for paper.

And essentially if that's said, if a health plan or a state Medicaid agency mandates paper compliance for NPI, and the legacy IDs continue to be sent by the providers and those - that paper is converted to electronic, but it is originally paper, is it CMS's position that the plan may reject because the provider did not submit an NPI?

Stanley Nachimson: Hi, this is Stanley Nachimson. I'm not sure we quite understood the question, but let me just explain in general. Health plans are permitted to require NPIs on paper transactions as Medicare has chosen to do. And they are certainly free to reject any paper claims that don't come in with NPIs.

(Gail Hyslop): That answers the question Stanley. Thank you.

Operator: Your next question comes from (Patricia Foley).

(Delores Fogart): Hi, this is (Delores Fogart) from (Mobilelux) USA.

David Clark: Hi (Delores).

(Delores Fogart): How are you? My question has to do with facility NPI number. We are a mobile x-ray company and doing lots of exams in many skilled facilities. And I just heard for the first time today that I'm going to need an NPI number for each location that I go to?

Kathy Simmons: You're a mobile facility that moves around like a van or something?

(Delores Fogart): Yes, that's correct.

Kathy Simmons: When we spoke of an NPI for each location, we were talking about something like a group practice with three different offices in different parts of the city. When billing for a van that moves around it's your permanent address really that is an issue here, not where you may go on a daily basis.

(Delores Fogart): Okay. Now we do report where we go on a day to day basis in the equivalent of Block 32 on our electronic claims or on a paper claim in Block 32.

Kathy Simmons: Yes, since you're providing the services at a location other than your billing address. But wherever you're sending your claims out from, and in your particular case I'm assuming that you only have one address in that locality?

(Delores Fogart): That's correct.

Kathy Simmons: So that would be your billing address.

(Delores Fogart): Yes. No, we were okay on our NPI. We didn't know if we needed to record the facility's NPI.

Kathy Simmons: That would go into field 32 of a revised CMS-1500 paper claim and into the 2310D loop of an 837-P claim.

(Delores Fogart): Okay, but it is or it is not required, because you've told me both ways?

Kathy Simmons: Both the institutional and the professional implementation guides say that an NPI, EIN or SSN would be reported in a service facility loop “if known”.

(Delores Fogart): Okay.

David Clark: Thank you.

Operator: Your next question comes from (Mary Ruth Keller).

(Mary Ruth Keller): Yes, I have several subgroups. I have one particular multi-specialty group which included my ER physicians and my anesthesiologist. Now under the new taxonomies, I can't find any place to put a hospital employee based - hospital based anesthesiologist.

He can't go with a CRNA. He can't go with an ER doc. So I'm just wondering what kind of subgroup for this one particular doctor we'd have to have?

Patricia Peyton: This is Pat Peyton. Can I get back to you on that? I'll put the code set in front of me.

(Mary Ruth Keller): Yes.

Patricia Peyton: Can you give me your number?

(Mary Ruth Keller): 828-835-7613

Patricia Peyton: Okay, thanks.

(Mary Ruth Keller): Uh-huh.

Operator: Your next question comes from (Diana Salmo).

(Diana Salmo): Yes, I think I'm going to be addressing this question to Pat. It's in reference to the parent facility. If you have a parent facility has an NPI and you have facilities that are working with that parent facility and say that parent facility closes and we haven't billed any of the other facilities under a different NPI, what happens? Do we need to sign up for a new NPI for the other facilities or can we continue to use that parent facility NPI?

Patricia Peyton: This is Pat Peyton. If the parent facility closes, wouldn't the subparts also be closed as part of the same?

(Diana Salmo): Not necessarily. What they will do is go to one of the other facilities and indicate that that is the new parent facility. But then you have when it comes to the billing part - this is where we're confused.

If you have 15 months to bill, so if we have a claim that we needed to bill under the original parent facility, and now we have a new partner facility and we try to bill some charges that were prior, they are going to say the NPI number was invalid. Am I making sense or am I confusing you?

Patricia Peyton: Somewhat. But I think some of that is going to be dependent on how the different health plans implement the NPI, like whether they'll look at legacy numbers to process the claims.

(Diana Salmo): Because the legacy number is the same for all. You'll have a main facility. I believe you're calling that a parent facility. And we may have three satellites from that.

And then let's say they came in in August and we decided that we needed to close that location, and one of the other facilities was now considered the parent facility.

We had the survey, they agree it could be the parent facility. We can't keep that same NPI number I'm thinking, because of the fact it's a new - the first facility closed.

Patricia Peyton: Why don't you let me give you a call so I can find somebody here who can help.

(Diana Salmo): Yeah if you don't mind please, because that's an issue we have when we have multiple facilities attached to a parent facility. My name again is (Diane). And I'm from Health South. And my number is 314-984-2157.

Patricia Peyton: All right. Thank you.

(Diana Salmo): Thank you.

Operator: Again please state your organization's name followed by your question. Your next question comes from (Penny Terrell).

(Penny Terrell): Hi, this is (Penny Terrell) from Syracuse Hematology Oncology. You might have answered this question but I want to make sure that I'm clear on this. We are a physician group practice with two locations. We have one tax ID number. And I'm just trying to find out how many NPI numbers I need for the group.

Pat Peyton: The group only needs one unless one of its locations conducts any of the HIPAA standard transactions.

(Penny Terrell): Okay. And so if we do our billing out of one location we are fine with one NPI and we're just distinguishing where the services were rendered?

Pat Peyton: That's correct.

(Penny Terrell): Okay. Thank you very much.

Operator: Your next question is from (Kristine Kaiser).

(Kristine Kaiser): Hi, this is (Kristine Kaiser) at Liberty Billing. We're a billing service and submit a large volume of professional claims on behalf of radiologists who are hospital based. Will there be a centralized location for obtaining NPIs for referring physicians?

Patricia Peyton: This is Pat Peyton. There will be information about that in the Data Dissemination Notice that I mentioned in my presentation, which we expect to have out very soon.

(Kristine Kaiser): Okay, thank you.

Operator: Your next question from (Carrie Dewitt).

(Carrie Dewitt): Hi my name is (Carrie). I'm calling from Reliable Medical. And my question is if we have a DBA, do we need a separate NPI number?

Patricia Peyton: This is Pat Peyton. A Doing Business As name?

(Carrie Dewitt): Yes.

Patricia Peyton: Well you can obtain, but you don’t need, a separate NPI for that. You have to figure out if you have subparts. If that would be a subpart, it could possibly be

the name of one of your subparts, but yes, that's your decision on how many NPIs you want your organization to have.

(Jim Bossenmeyer): But also remember that as you request your NPI you are providing your legal business name and your other identifying information. So you probably are not going to need NPIs for doing business names, but you only consider the implications for subparts.

(Carrie Dewitt): Okay, thank you.

Operator: Your next question comes from (Marcia Mahoney).

(Marcia Mahoney): Hi, (Marcia Mahoney), Health Associates. I'd like to know if the CMS 1500 is going to be revised again any time after May 23 of '07 to eliminate the legacy field?

(Kathy Simmons): This is (Kathy Simmons) at CMS. Actually the National Uniform Claim committee has been maintaining the 1500 and prepared the recently revised form. Typically they've only been updating the paper claim forms about once every ten years.

I don't know if they're going to wait ten years before they revise the 1500 again, but at this point they haven't indicated to us any intention to remove the shaded fields where the legacy numbers would go now.

(Marcia Mahoney): Thank you.

Operator: Your next question comes from (Debra Farley).

(Debra Fraley): Yes, I'm calling from (BillPro) Management Systems. We're a billing entity. I'm a little bit confused as far as taxonomy codes are concerned. How important or must they be reported on CMS-1500 claim form and are an electronic submissions for the providers? Because we're having providers picking out - if they're in a group practice, they are picking out legacy, or taxonomy numbers for clinics. And we don't know how important this is.

Patricia Peyton: This is Pat Peyton. Are you talking about on your claims?

(Debra Farley): Right, then we submit - how important do we have to put the taxonomy codes for the providers on an electronically submitted claim?

Kathy Simmons: Medicare doesn't actually require taxonomy codes for physicians and the like on either 837P or 1500 forms. In fact I don't even think there's a field for it on the 1500. But we do require taxonomy codes for certain institutional providers.

For instance if you are one of the hospitals that decides to get one NPI and you have multiple sub units within the hospital, such as a swing bed unit, where sometimes the beds are used for Skilled Nursing Facility (SNF) beds and sometimes they're regular hospital care, but the services in each setting get paid at different rates.

So if a hospital like that only obtained one NPI, they would need to report the taxonomy code so we would know that a particular bill applied to a special unit rather than a regular hospital bed. Taxonomy code reporting is optional for non-institutional Medicare bills right now.

(Debra Farley): Okay, and one more question. Maybe I misunderstood something, but it's a group practice and they have their one NPI number, I thought I heard someone

say it's up to the group as to whether the individual physicians should get an NPI?

Patricia Peyton: This is Pat Peyton. I did say that if they're not covered providers, the final rule doesn't require them to have NPIs but that some health plans might, and Medicare is one. If any of the physicians are enrolled in Medicare, they are going to have to have NPIs.

There are other ways they could be required as well. A health plan can just decide it wants NPIs everywhere a provider is identified in a claim.

(Debra Fraley): Well yes, because how would you report the rendering provider without his individual NPI number?

Kathy Simmons: That's why Medicare requires the NPI. We can't speak on behalf of any other payers. We do require that each physician get an NPI if he/she would be identified as the rendering provider on a bill submitted by a group.

(Debra Farley). Thank you.

Operator: Your next question comes from (Wilhelmina Torres).

(Wilhelmina Torres): Hello.

David Clark: Hi (Wilhelmina).

(Wilhelmina Torres): Hi. Okay, seeing as you mentioned that effective May 2007 you are going to be phasing out the UPIN registry. Okay, but will there be a location where we can check, you know, like where our providers provide services? Hello?

Pat Peyton: I'm not sure we understand the question.

(Wilhelmina Torres): Okay, hold on.

Pat Peyton: Hello?

David Clark: Yes.

(Speaker for Ms. Torres): Her question is on the UPIN registry. We are able to verify that the locations where - we're calling from a mental health agency, so some of our doctors that provide services here also provide either private practice or other locations.

And we've been helping them and assisting them with getting their NPIs. And in the process, like helping them fix the practice locations where they're allowed to provide service.

So with the UPIN registry we were able to see locations where they were authorized to practice. Is there going to be something like that with the NPI numbers where we're able to see the locations?

Patricia Peyton: Well the - this is Pat Peyton. The Data Dissemination Notice will talk about what data from the system would be made available. But keep in mind that in that system we only collect a mailing address and one practice location address for any provider.

(Speaker for Ms. Torres): Oh. So are they going to have trouble billing their private practice and us billing for the services that they're rendering here?

Patricia Peyton: Not as long as they are enrolled in the Medicare program. For Medicare purposes they should have identified their practice locations. But no, they wouldn't have any problems from our end. I don't know about your end.

(Speaker for Ms. Torres): Okay.

(Jim Bossenmeyer): And then if you are enrolling in the Medicare program today and sending in an enrollment application, it is required that you have an NPI prior to initiating that enrollment process.

(Speaker for Ms. Torres): Yeah, we've been doing all the paperwork for our doctors. They are kind of out (unintelligible). We do it for them and then they overlook it and…

David Clark: okay.

(Speaker for Ms. Torres): It's been a mess.

David Clark: All right, thank you. Operator?

Operator: Your next question comes from (Karen Topel).

(Karen Topel): Good afternoon. Thank you for the information.

David Clark: Thank you.

(Karen Topel): Okay, my question is am I correct in assuming that a legacy identifier is the current physician's current number now?

Patricia Peyton: This is Pat Peyton. It would be the number they use now to identify themselves as a provider. A legacy number from Medicaid might not be the same as the legacy number they use for Medicare or other health plans.

(Karen Topel): Okay. I'm calling from ENT and Allergy Associates. We're a multi-specialty group with many physicians in three states in the northeast. And we have - I have already applied for a NPI number for every physician and for the entity, the corporate entity.

We are incorporated in the State of New York, but we have offices in Connecticut and in New Jersey where the Medicare number for the group is different in those - in each state. Do I need an NPI number for each state?

Patricia Peyton: This is Pat Peyton. Only if those other locations do their own HIPAA transactions. Medicare will have to link your single NPI with the different locations otherwise, it would not know who performed the service.

(Karen Topel): Okay, the states already have those locations linked to the group Medicare number in each state. But - so the one NPI number will suffice for each state?

Patricia Peyton: The NPI is national. You can use it everywhere. But you know, unless those locations are conducting their own HIPAA transactions, the final rule doesn't require them to have NPIs.

(Karen Topel): Okay. And…

David Clark: I'm sorry. There are a number of folks on the line and I'd like to move on.

(Karen Topel): Okay.

David Clark: Okay, thank you.

Operator: Your next question comes from (Kathy Sykes).

(Kathy Sykes): Yes, this is (Kathy Sykes) from (Romed). And I'm trying to determine if CMS can provide any guidance on how to distinguish small health plans that have until 2008 to comply with NPI.

Stanley Nachimson: Are you asking if we have a list of small health plans? If you're asking if we have list of small health plans, no. The criteria for what is considered a small health plan is the health plan with annual receipts less than $5 million. But we do not have a list of those.

(Kathy Simmons): This is (Kathy Simmons). I just want to make a comment on that. Because there are a lot of people that seem to be confused and may think that the small providers have until 2008. That restriction or extension only applies to small health plans.

David Clark: Did we answer your question?

(Kathy Sykes): Yes, thank you.

David Clark: Okay, thank you.

Operator: Your next question comes from (Jo Wimmer).

(Jo Wimmer): Hi my name is (Jo Wimmer). I'm calling from (Unintelligible) Medical Center. We have one individual physician who has a Medicare provider ID. I already have my NPI for him.

But we also have a physical therapist within our group practice. He has his own Medicare ID. He was listed under our Medicare group ID but what I'm wondering is will we have to get him his own NPI number also, if that makes sense?

Patricia Peyton: This is Pat Peyton. Again, if he's not a covered provider, the Final Rule doesn't require him to have an NPI. But if he is enrolled in Medicare or enrolling, then he will need an NPI.

(Jo Wimmer): Okay, so he will not be under my NPI since he has his own Medicare number, he will have his own NPI number.

Patricia Peyton: Every provider who is a person is eligible for their own NPI.

Kathy Simmons: And for the Medicare bill, if he is the individual rendering the service he would have to be listed on the Medicare claim and identified with his NPI.

(Jo Wimmer): Okay, that's what I was thinking. Thank you very much.

David Clark: Thank you.

Operator: Your next question comes from (Denise Barth).

(Denise Barth): Yes, I'm calling from Rocky Mountain Radiologists. And we're a group of radiologists that read the x-rays out at the hospital. And we currently have to report the FDA certification number for - when doing screening mammographies. That FDA certification is reported in - currently reported in Block 32 for the hospital. Will I continue to report that there on the new (HCFA)?

(Kathy Simmons): Yes, this is (Kathy Simmons). Mammography certification numbers, and there are a couple of other certification numbers, such as CLIA lab numbers, that can still be reported.

Certification numbers are not treated as if they are legacy numbers. They and tax identifiers are not considered to be legacy numbers, so they would still be reported.

(Denise Barth): Okay, so I will have to report both the certification number and their NPI number?

(Kathy Simmons): Right, because in some cases such as you described, a facility has to establish that they are legally authorized to provide a service. It doesn't apply to all types of facilities-there aren't too many cases-but mammography is one of those cases.

(Denise Barth): Okay. And is there a specific place in Block 32 on the new form for that certification number or does it matter?

(Kathy Simmons): Actually I don't have that information with me. If you want to give me your name and phone number I can get back to you. I'm sure there is a place but I just don't remember which field it is right off.

ANSWER: The mammography certification number would be reported in the 2400 service loop of an 837-P claim with qualifier EW in REF01 and the mammography certification number in REF02.

(Denis Barth): Sure, my name is (Denise). And my phone number is 303-753-1191.

(Kathy Simmons): Okay, I'll get back to you (Denise).

(Denise Barth): Thank you.

Operator: Your next question comes from (Jeanne Knudson).

(Jeanne Knudson): Hi, I'm calling from the Hiawatha Community Hospital. And we have two questions. The first is, what happens if a parent entity obtains subpart NPI for eligible subpart entities but then finds it's easier to submit the data with the parent provider NPI? Is there a disadvantage to having those other NPI numbers out there?

And then my second question is can you explain the difference between a taxonomy differentiation and a subpart designation?

Patricia Peyton: This is Pat Peyton. The first part, if you're not going to use those NPIs for the subparts, they can be deactivated. There is a way to do that.

(Denise Knudson): So is it better to file more up front and then deactivate or try filing under just one and then add as you go?

Patricia Peyton: There is nothing we can say one way or the other here.

(Denise Knudson): What is your hunch?

Patricia Peyton: If you - pardon me?

(Denise Knudson): I said, do you have a hunch?

Patricia Peyton: I really don't. You know, if you didn't get enough you can always apply for some more. And if you got too many and you know you're never going to use them, then you can deactivate them.

And your other question dealt with the taxonomy code. I'm not positive I understood that question. A taxonomy code more or less classifies a provider by its type, specialization and other things like that, both people and organizations.

(Denise Knudson): It seems like there would be an opportunity to follow - to file for an NPI based on a taxonomy code and also as a subpart. I guess I'm trying to figure out what…

Patricia Peyton: Yes, and that example is given in the Final Rule. That the difference in taxonomy, meaning the type of provider that maybe one entity is - maybe it does two different types of things that would mean two different taxonomy codes. You could designate a subpart because of the difference in the taxonomy code.

(Denise Knudson): Okay, I guess we'll look up the Final Code. I don't know if that really answers that for me. I guess I just don't understand why you would choose to do a subpart versus a taxonomy.

Patricia Peyton: Why don't you let me call you, because I think there is a misconception here of some sort. What is your number?

(Denise Knudson): It's 785-742-6210.

Patricia Peyton: Okay, thanks.

(Denise Knudson): Thank you.

Operator: Your next question comes from (Debra Reinhardt).

(Debra Reinhardt): Pinnacle Health Hospitals. We have two quick questions. The first one is on our institutional claims we will have to report the taxonomy code for the facility along with the facility NPI number? With the attending physician, will we have to report his taxonomy code as well?

Kathy Simmons: Not for claims you send to Medicare.

(Debra Reinhardt): Okay.

Kathy Simmons: I don't know whether any other payers require it.

(Debra Reinhardt): Thank you. And (Lisa) has our second question.

(Lisa Getz): Hi, I'm (Lisa Getz) and I'm also from Pinnacle Health. And I'm responsible for doing all the individual NPI numbers for about 400 of the employee providers at Pinnacle Health.

Some are coming back rejected as already having a number. And is there a way to get a provider's NPI on behalf of the provider that we don't have to get the provider, you know, the provider to get it? Because I'm having difficulty doing that.

Patricia Peyton: This is Pat Peyton. It really is the responsibility of the provider to get his or her or its NPI. But if you're going to be applying on behalf of them, you really need to check with them first to see if they already have NPIs or if in fact they actually want you to do it. Some of them might want to do it themselves.

(Lisa Getz): Can I do a letter on behalf of the physician and have them sign it? That it could go to me? Is that…

Patricia Peyton: You mean as far as permission?

(Lisa Getz): Yes.

Patricia Peyton: Sure.

(Lisa Getz): Okay, and I can send that - would I send that to the NPI Enumerator in Fargo, North Dakota?

Patricia Peyton: No. You would use it to make sure that the physician has given you the okay to apply for his or her NPI.

(Lisa Getz): Well, if I do have permission for all of them. But some of them are coming back rejected. First instance, an ED physician may work at Pinnacle and also at Holy Spirit and Holy Spirit has already applied for the NPI number and they will not give me the NPI number. The provider has no idea what an NPI number is. I want to know how I can get it.

Patricia Peyton: Whoever applied for that physician's NPI, whoever they put down as the contact person, got a notification back with the NPI for the provider, with the instruction to share that NPI with the provider.

You're right, the Enumerator is not going to give out NPIs to anybody except the provider.

So you'll have to get in touch with the provider and find out what they know about it. The provider should be able to call the Enumerator or give you the name of the contact person, and you can call the contact person and explain the situation and get the number.

Sometimes the Enumerator will give the name of the contact person to the provider. But they are very, very careful as to whom they disclose an NPI to.

(Lisa Getz): Yeah, I'm having a lot of difficulty with that. But I don't know if (unintelligible) letters to (unintelligible) and have the physician sign it. That would be okay, is what you're saying?

(Jim Bossenmeyer): No, what we're suggesting that you do -- this is (Jim Bossenmeyer) -- is contact the physician before submitting that application to determine if he or she has already received an NPI.

In the event that they believe that they did not apply for their NPI but somebody has obtained the NPIs on their behalf, then the physician will be required to call the Enumerator to get the identifying information so that he can get the NPI from the individual who obtained their NPI.

(Lisa Getz): Thank you.

Operator: Your next question comes from (Brenda Olson).

(Brenda Olson): Hi, can you hear me?

David Clark: Yes.

(Brenda Olson): Okay. My main question is that we have - we're small rural hospitals. I work with about 25 of them. And we do billing for physicians that are actually coming into our facilities to do some work.

And a lot of them are CRNA providers and some are just regular providers. So my understanding is those providers will only have one NPI and that is the NPI that we will put on like the 1500 claim that like the 1500 claim that we're billing.

The question has been raised about that we used to be able to put the tax ID number there so that there would be a distribution in knowing where the dollars were going for that particular CRNA or physician and there is some question about whether we need to - whether that physician will have multiple NPI numbers, which I'm trying to tell them that they won't have, but I don't know how to explain further.

I had emailed the question in but I didn't seem to get the - it didn't seem to be answered during the first session. I'm sorry, I'm with (Great Place) Health Alliance in Kansas, or in (unintelligible) Kansas.

Patricia Peyton: This is Pat Peyton, and I can't even remember your question, I'm sorry.

(Brenda Olson): It's kind of convoluted but I know two or three of us emailed this in. But basically what it is is we have multiple - like a CRNA that is being seen - using his services are being used by like maybe five or six different facilities.

And those facilities are actually the biller for that CRNA. But they are not a hospital employee. They are actually on their own - they run their own service.

So my understanding would be that that CRNA - we would get that NPI number from that CRNA and that's what would be on our claims. And when I explained that to our hospital they said that no, we need to know the tax ID number to be able to identify what goes where.

(Kathy Simmons): Well actually you need both of them. This is (Kathy Simmons). If a provider is submitting the claim, both their NPI number and their tax ID number need to go in the billing provider loop. That's an implementation guide requirement for electronic claims. As long as the tax ID number is still used for IRS 1099 reporting purposes, it will still be required.

Patricia Peyton: And in the implementation guide -- this is Pat Peyton-- it will tell you that it's the tax number needed for tax purposes. And whenever that is the case, you would not use the NPI for that. You would have to use the TIN and the NPI where the provider is actually identified as a provider.

Kathy Simmons: The taxpayer identification number used to go in the field that's now to be used for the NPI on electronic claims and the tax identification number in that situation moves to the REF segment in that loop of the electronic claim.

(Brenda Olson): REF segment? Is that what you said?

Kathy Simmons: Yes. In the loop for the billing provider there is a REF segment that can be used to report numbers other than an NPI, including the tax identification number.

(Brenda Olson): So I should be fine by putting the NPI number and the tax ID number there? Because one of the issues was making sure that the facility be able to show what payment was coming back for them for that CRNA. And by putting that tax ID number in there, that will distribute that correctly?

(Kathy Simmons): Well I'm a little confused. This is (Kathy Simmons). You said “where the payment is coming back to”, is the hospital being paid for the physician? The CRNA service?

(Brenda Olson): Yeah, they are the ones doing the billing for them.

(Kathy Simmons): Okay, well they are…

(Brenda Olson): They'll have multiple facilities doing billing for maybe just one CRNA because he's being - his services are being provided at multiple facilities.

(Kathy Simmons): In order for someone other than the provider of the care to ever be paid by Medicare anyway, that provider has to - that CRNA would have to report to Medicare that they have authorized the hospital to collect payments on their behalf.

There is a place to report that information on an electronic claim, a pay to provider loop. But Medicare also requires that providers notify their local carrier if they are going to have the Medicare payment sent to anyone else - to someone else's address.

There are some limitations on who can receive payments for a particular Medicare provider, so that is why we need to have them contact Medicare directly.

(Brenda Olson): I don't think that answers my question though. Is there somebody I can maybe call in CMS with a couple other people from my company that are trying to figure out how to do this?

David Clark: No, I don't have a specific individual to call. But I'll take your information.

(Brenda Olson): That would be great.

David Clark: And what is your number?

(Brenda Olson): It's Brenda Olson), and my number is 785-256-3306.

David Clark: Thank you (Brenda).

(Brenda Olson): Thank you.

David Clark: Our next question please.

Operator: Your next question comes form (Trish Lily).

(Trish Lilly): Hi, This is (Trish Lilly) from Evangelical Community Hospital. And I just have really two quick questions. The first one is from being a facility and on my UB04, the NPI numbers, am I utilizing the actual individual physician numbers or the group number?

(Kathy Simmons): This is (Kathy Simmons). First, a lot of people have been talking about the paper billing form today. I'm not sure if you're aware, there is another piece of legislation that came out a few years ago, the Administration Simplification Compliance Act that says, for instance, if you're a Medicare hospital, the only way you can submit a paper bill is if you have fewer than 25 employees working for the hospital, or for any type of an institutional provider.

And if you're a Medicare physicians' practice or some type of professional provider--the type that would have used the 1500 or a 837 professional format in the past-- that practice would have to have fewer than ten full time equivalent employees in order to submit a paper bill.

Now Medicare is reviewing all of those providers that have been submitting paper bills to us to make sure that they meet those limitations, or alternately meet some additional exception criteria. There are very few exception criteria that would allow you to submit paper bills, if you're not considered a small provider. The law says, if you're not small and do not qualify for an exception, you must submit a claim to Medicare electronically to get paid.

So I just wanted to clarify that right off. I'm a little concerned about all these continuing references to paper bills. For the most part we're trying to reduce paper billing because it costs more to process and is more problematic.

(Trish Lilly): Okay. I don't know if maybe I missed that. Maybe I wasn't saying that correctly. All I'm looking for - I'm not even talking paper because we do all of ours electronic. I don't even send paper.

My question is if I'm going to be - my information is coming out of my UB04 for my physicians, is it going - when I say that physicians, my attending, my, you know, PCP whatever, I should be utilizing their individual NPI numbers on my claim form on my claim?

Kathy Simmons: Yes. You're right. If you're reporting an attending physician on an institutional claim you will need to report their NPI May 23,2007 or later. The institutional claim implementation guide says that if you report information on an attending, operating physician and/or an other physician that you must report their NPI (effective May 23, 2007 and later).

(Trish Lilly): Okay, and the only other one quick question is is do you see this as being a big issue with having delayed payments coming back because of all the issues with the NPIs?

Kathy Simmons: Not if you report NPIs for physicians who have already obtained their NPIs in the NM1 segment and their legacy numbers in the REF segment of the same loop through May 22, 2007. That would help us to identify and eliminate any potential problems prior to May 23, 2007 when legacy numbers may no longer be submitted and correction could take longer. Other than helping to resolve problems when submitted with corresponding legacy identifiers, we don't think there should be any difficulty associated with submission of NPIs on Medicare claims prior to May 23.

(Trish Lilly): Okay. Thank you.

David Clark: Thank you.

Operator: Your next question comes from (Shana Harding).

(Shana Harding): Does the UPIN number, is it replaced by the NPI?

Pat Peyton: Yes.

(Shana Harding): Thank you.

David Clark: Thank you very much (Shana). Operator, we have time for two more questions.

Operator: Your next question comes from (Nan Chising).

(Nan Chising): Yes, I wanted to withdraw my question.

David Clark: All right. Thank you. And our last question please.

Operator: Your last question comes from (John Reed).

David Clark: Hi (John).

(John Reed): Thank you. Look, I work for a public health department in North Carolina and I'm attempting to fill out the application to get our NPI. We're going to have subparts and my question is--I have to obviously - or I'm assuming obviously--I have to submit a separate application for each NPI. Is that correct?

Patricia Peyton: This is Pat Peyton. Yes that's right.

(John Reed): And for the - on the subparts the application is asking for a name, a legal name. Obviously the subparts don't have a legal name. They are just, you know, some sort of, you know…

Woman: The “dba” name.

(John Reed): Yeah, I mean we can make them up.

Patricia Peyton: Well I think they -- this is Pat Peyton -- I think they do have a name that they go by, isn't that right, the “doing business as” name, usually?

(John Reed): Well not - no. I mean they could be just a separate service that we provide with a different taxonomy code.

Patricia Peyton: Well you have to think about why you want them to have NPIs, but then you would have to use the legal business name of the covered provider then if they - I…

(John Reed): So our…

Patricia Peyton: I don't know who would get an NPI that has no name though.

Kathy Simmons: Wouldn't this be a similar situation to like a special unit in a hospital – Pat, the special unit in a hospital doesn't necessarily have a separate name.

(John Reed): Exactly.

Patricia Peyton: Well the hospital has a name though.

(John Reed): So am I going to have two different NPIs with the same legal name and same employer identification number and the only difference just being the taxonomy code?

Patricia Peyton: That's possible, but the Enumerator will probably call whoever sent the second application that comes in to make sure that in fact it's not for the same provider that already got one with that very same information except for the taxonomy code.

(John Reed): I mean I would think that would b a problem that any entity that was going to have subparts would have.

Patricia Peyton: A name problem? Maybe so. I've not been asked the question before.

(John Reed): Yeah.

Kathy Simmons: If they did use different names they probably would not be called.

(John Reed): I Mean I - we could certainly you know, dash child health, dash maternal health, something like that. But that's not a legal name. That's probably doing business as name or something.

Pat Peyton: Well there is a place for the “doing business as” name on the NPI application.

(John Reed): Right, right. Okay.

David Clark: Okay, (John) thank you very much.

(John Reed): Thank you. Thanks very much

David Clark: Just a couple of closing remarks. There will be a transcript of the call. I said it would be available immediately. That will actually be about one week that it will be posted up on the Web site. So in one week we'll have a transcript of today's call.

As far as the Data Dissemination Notice it's not clear when it will be published, but when it is, it will be published in the Federal Register. It will be posted on CMS NPI Web site as well as announced through the various CMS list serves and other channels to which we share information.

The next call is not scheduled. We expect it to be sometime around the beginning of the year.

And the last piece is the Web site. I just want to encourage you to take a look at our Web site for additional information.

That's www.cms.hhs.gov/nationalprovidentstand/ . That's national, N-A-T-I-O-N-A-L, prov, P-R-O-V, ident, I-D-E-N-T, stand, S-T-A-N-D, all one word.

Thank you all very much for your attention this afternoon and that concludes today's call. Thank you.

Operator: This concludes today's Centers for Medicare and Medicaid Services National Provider Identifier Round Table conference call. You may now disconnect.

END