CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 227	Date: NOVEMBER 2, 2007
	Change Request 5795

SUBJECT: Update to Requirement to Submit National Provider Identifier (NPI) Notification

I. SUMMARY OF CHANGES: This change request revises the Division of Provider and Supplier Enrollment"s (DPSE) current policy relating to the circumstances under which a provider or supplier must submit a copy of its National Provider Identifier (NPI) notification to the Medicare contractor.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2008
IMPLEMENTATION DATE: JANUARY 7, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/4.21/National Provider Identifier (NPI)

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 227	Date: November 2, 2007	Change Request: 5795

SUBJECT: Update to Requirement to Submit National Provider Identifier (NPI) Notification

Effective Date: **January 1, 2008**

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: This emergency change request revises the Division of Provider and Supplier Enrollment's (DPSE) current policy relating to the circumstances under which a provider or supplier (hereinafter collectively referred to as "provider") must submit a copy of its National Provider Identifier (NPI) notification to the Medicare contractor.

B. Policy: The purpose of this emergency change request is to clarify the aforementioned policy. In short, the provider is no longer required to submit to the contractor a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES), unless requested to do so by the contractor. Similarly, if the provider obtained its NPI via the Electronic File Interchange (EFI) mechanism, the provider need not submit a copy of the notification it received from its EFI Organization (EFIO), unless requested to do so by the contractor. If paper documentation of a provider's NPI is requested by the contractor, the latter may accept a copy of the provider's NPI Registry's Details Page in lieu of a copy of the NPI notification.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5795.1	The contractor shall note that the provider is no longer required to submit a copy of its NPI notification to the former, though the contractor retains the discretion to request said notification if deemed necessary.	X		X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5795.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X	X					

IV. SUPPORTING INFORMATION

X-Ref Requirement Number	Recommendations or other supporting information:

V. CONTACTS

Pre-Implementation Contact: Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov.

Post-Implementation Contact: Frank Whelan, (410) 786-1302, frank.whelan@cms.hhs.gov

VI. FUNDING

A. ***For Fiscal Intermediaries and Carriers*****:** No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MACs)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

4.21 – National Provider Identifier (NPI)

(Rev.227, Issued: 11-02-07, Effective: 01-01-08, Implementation: 01-07-08)

A. Submission of NPI

Every provider that submits an enrollment application must furnish *its NPI(s)* in the applicable *section(s)* of the CMS-855. *The provider need not* submit a copy of the NPI notification it received from the National Plan and Provider Enumeration System (NPPES) *unless requested to do so by the contractor. Similarly, if* the provider obtained its NPI via the Electronic File Interchange (EFI) mechanism, the provider *need not* submit a copy of the notification it received from its EFI Organization (EFIO) *unless requested to do so by the contractor.* (The notification from the EFIO will be in the form of a letter or e-mail.*) If paper documentation of a provider's NPI is requested by the contractor, the latter may accept a copy of the provider's NPI Registry's Details Page in lieu of a copy of the NPI notification. The Details Page contains more information than is contained on the NPI notification, and providers may be able to furnish NPI Registry Details Pages more quickly than copies of their NPI notifications.*

The aforementioned *requirement to list all applicable NPIs on the CMS-855* applies to all applications listed in sections 2.1 and 2.2 of this manual. (The only exceptions to this involve voluntary terminations, deactivations, deceased providers, and CHOW applications submitted by the old owner. NPIs are not required in these instances.) Thus, for *instance, if* a reassignment package (as described in section 5.4 of this manual) is implicated, the *NPIs for* all involved individuals and entities must be furnished; even if an individual is reassigning benefits to an enrolled group, the group's NPI must be furnished on the *CMS-855R.*

If the provider fails to submit the mandatory NPI data, the contractor shall follow the instructions in section 3.1 of this manual.

B. Additional NPI Information

If a provider submits an NPI notice to the contractor as a stand-alone document (i.e., no CMS 855 was submitted), the contractor shall not create an L & T record in PECOS for the purpose of entering the NPI. The contractor shall simply place the notice in the provider file. Contractors shall only enter NPI data into PECOS that is submitted in conjunction with a CMS 855 (e.g., initial, change request). Thus, if a provider submits a CMS 855 change of information that only reports the provider's newly assigned *NPI, or reports multiple NPIs that need to be associated with a single Medicare identification number, the* contractor may treat this as a change request and enter the data into PECOS.

C. Subparts - General

The contractor shall review and become familiar with the principles outlined in the "Medicare Expectations Subpart Paper," the text of which follows below

CMS encourages all providers to obtain NPIs in a manner similar to how they receive OSCAR numbers (i.e., a "one-to-one relationship"). For instance, suppose a home health agency is enrolling in Medicare. It has a branch as a practice location. The main provider and the branch will typically receive separate (albeit very similar) OSCAR numbers. It would be advisable for the provider to obtain an NPI for the main provider and another one for the branch – that is, one NPI for each OSCAR number.

Further instructions on how contractors shall deal with NPI-related matters will be issued in the near future.

D. Medicare Subparts Paper - Text

MEDICARE EXPECTATIONS ON DETERMINATION OF SUBPARTS BY MEDICARE ORGANIZATION HEALTH CARE PROVIDERS WHO ARE COVERED ENTITIES UNDER HIPAA

January 2006

Purpose of this Paper

Medicare assigns unique identification numbers to its enrolled health care providers that are used to identify the enrolled health care providers in the HIPAA standard transactions that they conduct with Medicare (such as electronic claims, remittance advices, eligibility inquiries/responses, claim status inquiries/responses, and coordination of benefits) and in cost reports and other non-standard transactions.

This paper is a reference for Medicare carriers and fiscal intermediaries (FIs). It reflects the Medicare program's expectations on how its enrolled organization health care providers who are covered entities under HIPAA1 will determine subparts and obtain NPIs for themselves and any subparts. These expectations may change over time to correspond with any changes in Medicare statutes, regulations, or policies that affect Medicare provider enrollment.

These expectations are based on the NPI Final Rule, on statutory and regulatory requirements with which Medicare must comply, and on policies that are documented in Medicare operating manuals but have not yet been codified. These Medicare statutes, regulations and policies pertain to conditions for provider participation in Medicare, enrollment of health care providers in Medicare and assignment of identification numbers for billing and other purposes, submission of cost reports, calculation of payment amounts, and the reimbursement to enrolled providers for services furnished to Medicare beneficiaries.

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1 Covered entities under HIPAA are health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a health transaction for which the Secretary of HHS has adopted a standard (referred to in this paper as HIPAA standard transactions). Most Medicare Organization health care providers send electronic claims to Medicare (they are HIPAA standard transactions), making them covered health care providers (covered entities).

This paper categorizes Medicare's enrolled organization health care providers as follows:

- Certified providers and suppliers
- Supplier groups and supplier organizations
- Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

This paper is not intended to serve as official HHS guidance to the industry in determining subparts for any covered health care providers other than those who are organizations and are enrolled in the Medicare program. This paper does not address health care providers who are enrolled in Medicare as individual practitioners. These practitioners are Individuals (such as physicians, physician assistants, nurse practitioners, and others, including health care providers who are sole proprietors). In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI. As Individuals, these health care providers cannot be subparts and cannot designate subparts. A sole proprietorship is a form of business in which one person owns all of the assets of the business and the sole proprietor is solely liable for all of the debts of the business. There is no difference between a sole proprietor and a sole proprietorship. In terms of NPI assignment, a sole proprietor/sole proprietorship is an Entity Type 1 (Individual) and is eligible for a single NPI. As an Individual, a sole proprietor/sole proprietorship cannot have subparts and cannot designate subparts.

Discussion of Subparts in the NPI Final Rule and its Applicability to Enrolled Medicare Organization Health Care Providers

The NPI Final Rule adopted the National Provider Identifier (NPI) as the standard unique health identifier for health care providers for use in HIPAA standard transactions. On or before May 23, 2007, all HIPAA covered entities (except small health plans), to include enrolled Medicare providers and suppliers that are covered entities, must obtain NPIs and must use their NPIs to identify themselves as "health care providers" in the HIPAA standard transactions that they conduct with Medicare and other covered entities. Covered organization health care providers are responsible for determining if they have "subparts" that need to have NPIs. If such subparts exist, the covered organization health care provider must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

The NPI Final Rule contains guidance for covered organization health care providers in determining subparts. Subpart determination is necessary to ensure that entities within a covered organization health care provider that need to be uniquely identified in HIPAA standard transactions obtain NPIs for that purpose.

The following statements apply to **all** entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization health care provider that is a legal entity. (All covered entities under HIPAA are legal entities.)

- A subpart furnishes health care as defined at 45 CFR 160.103.

The following statements may relate to some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.

- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

- Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. Medicare covered organization health care providers must take any such statutes or regulations into account to ensure that, if Medicare providers are uniquely identified now by using Medicare identifiers in HIPAA standard transactions, they obtain NPIs in order to ensure they can continue to be uniquely identified. Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions (for organizations, these could be OSCAR Numbers, PINs, or NSC Numbers—known as legacy identifiers or legacy numbers) to NPIs. This makes it necessary that Medicare organization health care providers obtain NPIs because the NPIs will replace the identifiers currently in use in standard transactions with Medicare and with all other health plans. In addition, Medicare organization health care providers must determine if they have subparts that need to be uniquely identified for Medicare purposes (for example, in HIPAA standard transactions conducted with Medicare). If that is the case, the subparts will need to have their own unique NPIs so that they can continue to be uniquely identified in those transactions.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Enrolled Medicare organization health care providers who are covered entities under HIPAA must apply for NPIs as Organizations (Entity Type 2). Organization health care providers as discussed in this paper are corporations or partnerships or other types of businesses that are considered separate from an individual by the State in which they exist. Subparts of such organization health care providers who apply for NPIs are also Organizations (Entity Type 2).

Medicare Statutes, Regulations, Manuals

The Social Security Act (sections 1814, 1815, 1819, 1834, 1861, 1865, 1866, and 1891) and Federal regulations (including those at 42 CFR 400.202, 400.203, 403.720, 405.2100, 409.100, 410.2, 412.20, 416.1, 418.1, 424, 482.1, 482.60, 482.66, 483, 484, 485, 486, 489, 491, and 493.12) establish, among other things, the Conditions for Participation for Medicare providers and set requirements by which Medicare enrolls providers, requires cost reports, calculates reimbursement, and makes payments to its providers. These Medicare statutory and regulatory requirements are further clarified in various Medicare operating manuals, such as the State Operations Manual and the Program Integrity Manual, in which requirements and policies concerning the assignment of unique identification numbers, for billing and other purposes, are stated.

Medicare Organization Providers and Subparts: Certified Providers and Suppliers

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to Medicare certified providers and suppliers for billing purposes.

Certified Providers that bill Medicare fiscal intermediaries (hereinafter referred to as "providers"):

- Providers apply for Medicare enrollment by completing a CMS-855A.
- Most providers are surveyed and certified by the States3 prior to being approved as Medicare providers.
- Providers have in effect an agreement to participate in Medicare.4
- Providers include, but are not limited to: skilled nursing facilities, hospitals5, critical access hospitals, home health agencies, rehabilitation agencies (outpatient physical therapy, speech therapy), comprehensive outpatient rehabilitation facilities, hospices, community mental health centers, religious non-medical health care institutions.
- Providers are assigned OSCAR numbers to use to identify themselves in Medicare claims and other transactions, including cost reports for those providers that are required to file Medicare cost reports.
- In general, each entity that is surveyed and certified by a State is separately enrolled in Medicare and is considered a Medicare provider. (An exception involves home

2 Clinical laboratory certification is handled by the Food and Drug Administration.
3 Religious non-medical health care institutions are handled differently.
4 Community mental health centers attest to such an agreement. Religious non-medical health care institutions are handled differently.
5 Hospitals bill carriers for certain types of services.

health agency branches. The branches are not separately enrolled Medicare providers.) In many cases, the enrolled provider is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

Certified Suppliers, most of which bill Medicare carriers:

- Certified suppliers apply for Medicare enrollment by completing a CMS-855B.

- Certified suppliers include ambulatory surgical centers, portable x-ray suppliers, independent clinical labs (CLIA labs), rural health centers, and federally qualified health centers.

- Most certified suppliers bill the carriers; however, rural health centers and federally qualified health centers bill the fiscal intermediaries.

- Certified suppliers are typically surveyed and certified by the States prior to being approved for enrollment as Medicare certified suppliers. (For CLIA labs, each practice location at which lab tests are performed must obtain a separate CLIA Certificate for that location, though there are a few exceptions to this.)

- Certified suppliers may have in effect an agreement to participate in Medicare.

- Certified suppliers are assigned OSCAR numbers for purposes of identification within Medicare processes. However, the carriers assign unique identification numbers to certified suppliers for billing purposes. (For CLIA labs, a CLIA Number is typically assigned to each practice location for which a CLIA certificate is issued. A CLIA Number may not be used to identify a clinical laboratory as a "health care provider" in HIPAA standard transactions. The CLIA Number has no relation to the Medicare billing number.)

- In many cases, the enrolled certified supplier is not itself a separate legal entity; i.e., it is an entity that is a part of an enrolled provider or certified supplier that is a legal entity and is, for purposes of the NPI Final Rule, considered to be a subpart.

In general, Medicare bases its enrollment of providers and certified suppliers on two main factors: (1) whether a separate State certification or survey is required, and (2) whether a separate provider or certified supplier agreement is needed. (The Taxpayer Identification Number, or TIN, is a consideration as well, though not to the degree of the two main factors.) The CMS regional offices generally make the final determinations on both of these factors; hence, Medicare provider and certified supplier enrollment policy is dictated to a significant degree by the CMS regional offices' decisions in particular cases.

Medicare Expectations for NPI Assignments for Providers and Certified Suppliers:
To help ensure that Medicare providers and certified suppliers do not experience denials of claims or delays in Medicare claims processing or reimbursement, **Medicare**

encourages each of its enrolled providers and certified suppliers to obtain its own unique NPI. These NPIs will eventually replace the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports. In order for subpart determinations to mirror Medicare enrollment, each enrolled provider and certified supplier that is a covered organization health care provider would ensure the following:

- Obtain its own unique NPI.

- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, a total of 11 unique NPIs should be obtained: one by the hospital, and one by each of the 10 home health agencies.

Regardless of how an enrolled provider or certified supplier that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled provider or certified supplier.

Medicare Organization Providers and Subparts: Supplier Groups and Supplier Organizations

Existing Medicare laws and regulations do not establish requirements concerning the assignment of unique identification numbers to supplier groups and supplier organizations for billing purposes.

- Supplier groups and supplier organizations apply for Medicare enrollment by completing a CMS-855B.

- Supplier groups and supplier organizations bill Medicare Part B carriers.

- Supplier organizations are certified by the States, or certified by the Food and Drug Administration (FDA), or must undergo an on-site inspection by the carrier. These requirements vary by type of supplier organization.

- Supplier groups are primarily group practices, such as a group of physicians or other practitioners.

- Supplier organizations include ambulance companies, mammography facilities, and independent diagnostic testing facilities (IDTFs).

Medicare enrolls supplier groups/supplier organizations based on Taxpayer Identification Numbers (TINs); that is, although a supplier group or supplier organization may have

multiple locations, if each location operates under the same single TIN, Medicare does not separately enroll each location. There are exceptions:

1. When there is more than one Medicare specialty code associated with a single TIN. For instance, if a physician group practice is also an IDTF, it has two different Medicare specialties. The supplier group (the physician group practice) must enroll as a group and the supplier organization (the IDTF) must enroll as a supplier organization. The group practice would complete a CMS-855B and the IDTF would complete a CMS-855B. Each one would receive its own unique Medicare billing number.

2. If a separate site visit, State certification, or on-site inspection by the carrier or if FDA certification is required for each practice location of that supplier group/supplier organization.

In those above exceptions, Medicare separately enrolls each different Medicare specialty and each separately visited, certified or carrier-inspected practice location.

Medicare Expectations for NPI Assignments for Supplier Groups and Supplier Organizations: To help ensure that Medicare supplier groups and supplier organizations do not experience delays in Medicare claims processing or reimbursement, **Medicare encourages each of its enrolled supplier groups and supplier organizations to obtain its own unique NPI. These NPIs will eventually replace the legacy numbers that are used today in HIPAA standard transactions and in other transactions, such as cost reports.** In order for subpart determinations to mirror Medicare enrollment, each enrolled supplier group and supplier organization that is a covered organization health care provider would ensure the following:

- Obtain its own unique NPI.

- Determine if it has any subparts that are themselves enrolled Medicare providers. If there are subparts, ensure that they obtain their own unique NPIs, or obtain the NPIs for them. Example: An enrolled IDTF has four different locations, and each one must be separately inspected by the carrier. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, a total of four unique NPIs should be obtained: one for each location.

Regardless of how an enrolled supplier group or supplier organization that is a covered organization health care provider determines subparts (if any) and obtains NPIs (for itself or for any of its subparts, if they exist), Medicare payments, by law, may be made only to an enrolled supplier group or supplier organization.

Medicare Organization Providers and Subparts:
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)

Medicare regulations require that each practice location of a supplier of DMEPOS (if it has more than one) must, by law, be separately enrolled in Medicare and have its own unique Medicare billing number.

- A supplier of DMEPOS enrolls in Medicare through the National Supplier Clearinghouse (NSC) by completing a CMS-855S.

- Suppliers of DMEPOS bill Durable Medical Equipment Regional Carriers (DMERCs).

- Suppliers of DMEPOS include but are not limited to pharmacies, oxygen suppliers, and outpatient physical therapy agencies. (Any organization that sells equipment or supplies that are billed to Medicare through the DMERCs must be enrolled as a Supplier of DMEPOS through the NSC. Sometimes, these are organizations who also furnish services that are covered by Medicare, such as ambulatory surgical centers. In order to be reimbursed for the DME supplies that they sell, they must separately enroll in Medicare as a Supplier of DME.)

Medicare Expectations for NPI Assignments for Suppliers of DMEPOS: Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI.

Final Notes About NPIs

Enrolled organization health care providers or subparts who bill more than one Medicare contractor: An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor. For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

Enrolled organization health care providers or subparts who bill more than one type of Medicare contractor: Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor. However, in certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as more than one type of provider. For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier and bills a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the fiscal intermediary and the DMERC. Medicare expects that this ambulatory surgical center would report two different Taxonomies when it applies for its NPI: (1) that of Ambulatory Health Care Facility—Clinic/Center--Ambulatory Surgical

(261QA1903X) and (2) that of Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) **or** the appropriate sub-specialization under the 332B00000X specialization.

Enrolled organization health care providers who determine subparts for reasons unrelated to Medicare statutes, regulations or policies:

Consistent with the NPI Final Rule, covered organization health care providers designate subparts for reasons that are not necessarily related to Medicare statutes or regulations. If a Medicare organization health care provider designates as subparts entities other than those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, those NPIs will not identify enrolled Medicare providers. Medicare is not required to enroll them. (NPI Final Rule, page 3441: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls."))

Medicare will, of course, use NPIs to identify health care providers and subparts in HIPAA standard transactions. (NPI Final Rule, page 3469: section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.") Medicare will ensure that the NPIs it receives in HIPAA standard transactions are valid6. Medicare will reject HIPAA standard transactions that contain invalid NPIs. Valid NPIs, however, like the provider identifiers used today, must be "known" to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers7, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

6 The check-digit algorithm will determine the validity of an NPI. This is not the same as knowing the health care provider being identified by a particular NPI.

7 There may be exceptions for emergency or very unusual situations.