

Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule

AFTER THE MAY 23, 2007, IMPLEMENTATION DEADLINE

BACKGROUND

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which included a series of “administrative simplification” provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions and code sets and identifiers to be used in those transactions. The final rule adopting the NPI as the standard unique health identifier for health care providers was published on January 23, 2004, and became effective on May 23, 2005. All covered entities must be in compliance with the NPI provisions by May 23, 2007, except for small plans, which must be in compliance by May 23, 2008.

Compliance means in part that the NPI must be used by covered entities to identify providers on all HIPAA covered transactions that call for health care provider identifiers. Covered transactions that require a health care provider’s identifier that are transmitted containing only legacy identifiers (identifiers in use today) or containing both legacy identifiers and NPIs would be noncompliant.

The NPI final rule is clear: May 23, 2007 is the final deadline for covered entities, other than small plans, to comply with HIPAA’s NPI provisions. After that date, covered entities, including health plans (other than small health plans), may not conduct noncompliant transactions. With the May 2007 deadline just ahead, HHS has received a number of inquiries expressing concern over the health care industry’s state of readiness. In response, the Department believes it is particularly important to outline its approach to enforcement of HIPAA’s NPI provisions. The Department will continue to provide technical assistance to the industry and issue guidance on the NPI provisions and compliance requirements.

ENFORCEMENT APPROACH

The Secretary has delegated to the Administrator of the Centers for Medicare & Medicaid Services (CMS) authority to enforce the electronic transactions, code set, security, and identifier provisions (i.e., non-privacy administrative simplification provisions) of HIPAA. CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement. When CMS receives a complaint about a covered entity that appears to allege a failure to comply with a non-privacy administrative simplification provision of HIPAA, it will notify the entity in writing that a complaint has been filed. Following notification from CMS, the entity will have the opportunity to 1) demonstrate compliance, 2) document its good faith efforts to comply with the standards, and/or 3) submit a corrective action plan.

GOOD FAITH POLICY

CMS's approach will utilize the flexibility granted in section 1176(b) of the Social Security Act to consider good faith efforts to comply when assessing individual complaints. Under section 1176(b), HHS may not impose a civil money penalty where the failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period. HHS has the authority under the statute to extend the period within which a covered entity may cure the noncompliance "based on the nature and extent of the failure to comply."

CMS recognizes that transactions often require the participation of two covered entities, each of whom is required to comply with HIPAA, and that noncompliance by one covered entity may put the second covered entity in a difficult position. CMS also understands that if one of the covered entities is a small health plan, which has a May 23, 2008 compliance date, compliance by the covered trading partner may be especially challenging. Therefore, during the 12 month period immediately following the May 23, 2007 compliance date for all covered entities other than small health plans, CMS intends to look at both covered (non-small health plans) entities' good faith efforts to come into compliance with the NPI standards in determining, on a case-by-case basis, whether reasonable cause for the noncompliance exists and, if so, the extent to which the time for curing the noncompliance should be extended.

For a 12 month period after the compliance date (i.e., through May 23, 2008), CMS will not impose penalties on covered entities that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable and diligent efforts to become compliant and, in the case of health plans (that are not small health plans), to facilitate the compliance of their trading partners. Specifically, as long as a health plan (that is not a small health plan) can demonstrate to CMS its active outreach/testing efforts, it can continue processing payments to providers. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress. We limit the period during which covered entities may deploy contingency plans to allow additional time to carry out needed testing and other activities without payment disruption, while providing a clear ending date for those activities. A covered entity may end its contingency plan at any time prior to May 23, 2008, but cannot continue it after that date.

Indications of good faith might include, for example, such factors as:

- Increased external testing with trading partners.
- Lack of availability of, or refusal by, the trading partner(s) prior to May 23, 2007 for health plans (other than small health plans) to test the transaction(s) with the covered entity whose compliance is at issue.
- In the case of such a health plan, concerted efforts in advance of the May 23, 2007 and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider community.
- For a health care provider, having obtained an NPI and having the ability to use it on HIPAA transactions.

While there are many examples of complaints that CMS may receive, the following is one example that illustrates how CMS expects the process to work.

Example: A complaint is filed against a health plan (that is not a small health plan) solely because it accepts and processes transactions containing both legacy identifiers and NPIs while working to help its provider trading partners achieve compliance.

In this situation, CMS would 1) notify such a plan of the complaint, 2) based on the plan's response to the notification, evaluate the plan's efforts to help its noncompliant providers come into compliance, and 3) if it is determined that the plan had demonstrated good faith and reasonable cause for its non-compliance, not impose a penalty for the period of time CMS determines is appropriate, based on the nature and extent of the failure to comply.

For example, CMS would examine whether the health plan (that is not a small health plan) undertook a course of outreach actions to its trading partners on awareness and testing, with particular focus on the actions that occurred prior to the May 23, 2007 NPI compliance date. Similarly, health care providers should be able to demonstrate that they took actions to become compliant prior to the May 23, 2007 NPI compliance date, including obtaining an NPI. If CMS determines that reasonable and diligent efforts have been made, the cure period for noncompliance would be extended at the discretion of CMS. Furthermore, CMS will continue to monitor the covered entity to ensure that their sustained efforts bring progress towards compliance. If continued progress is not made, CMS will step up their enforcement efforts towards that covered entity.

Organizations that have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should document such efforts in the event of a complaint being filed. This flexibility will permit health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the 12 month transition to the NPI standards, as well as on the availability and quality of patient care.

WORKING TOWARD COMPLIANCE

In the few remaining months before the May 23, 2007 deadline for all covered entities other than small health plans, HHS encourages those covered entities to intensify their efforts toward achieving compliance with the NPI requirements. In addition, HHS encourages health plans that are not small health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Although compliance with the NPI is a huge undertaking, the result will be greatly enhanced electronic communication throughout the health care community. Successful implementation will require the attention and cooperation of all health plans and clearinghouses, and of all providers that conduct electronic transactions. HHS plans to reassess industry readiness on the May 23, 2007 compliance date, and throughout the 12 month contingency plan period.