CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1227	**Date: APRIL 24, 2007**
	Change Request 5595

NOTE: Transmittal 1225 dated April 20, 2007 is rescinded and replaced with Transmittal 1227, dated April 24, 2007. The second paragraph and second sentence was modified to Read "As long as covered entities, including health plans and covered health care providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners". The word compliant was removed from the third sentence. All other information remains the same.

Subject: Medicare Fee for Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan

I. SUMMARY OF CHANGES: Medicare Fee for Service (FFS) NPI Implementation Contingency Plan

New / Revised Material
Effective Date: May 23, 2007
Implementation Date: May 23, 2007

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

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

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

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SUBJECT: Medicare Fee-For-Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan

Effective Date: May 23, 2007

Implementation Date: May 23, 2007

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. CMS began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only
- Medicare legacy only
- NPI and legacy combination

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as covered entities, including health plans and covered health care providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a health plan, Medicare fee for service (FFS) is establishing a contingency plan that follows this guidance. This CR outlines Medicare's FFS contingency plan.

B. Policy: For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers; it will also accept transactions with only NPIs, and transactions with both NPI and legacy identifiers. After May 23, 2008, the legacy number will NOT be permitted on any inbound or outbound transaction. Medicare FFS has been assessing health care provider submission of NPIs on claims submitted. As soon as the number of claims submitted with an NPI for primary providers (see Important Information below) is sufficient to do so, Medicare will begin rejecting claims without an NPI for primary providers following appropriate notice. In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If the analysis shows a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims on July 1, 2007, that do not contain NPIs. If a sufficient number of claims do not contain NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007. Medicare FFS will provide advanced notification to providers, Medicare contractors and the shared systems of the

date they are to begin rejecting claims when a decision has been made to do so. That date will supersede all dates announced in previous CRs.

CMS recognizes that the National Council for Prescription Drug Program (NCPDP) format permits reporting of only one identifier, and will accept either the NPI or legacy number on the NCPDP format until May 23, 2008. In regard to the remittance advice and the 837 coordination of benefits (COB) transactions, the following will occur until May 23, 2008:

- if a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice, otherwise the legacy number will be provided;
- if a claim is submitted with an NPI, the 837 coordination of benefits (COB) transaction will contain both the NPI and the legacy number, otherwise the legacy number will be provided.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via Extranet and Internet must contain the NPI.

Important Information

This CR provides guidance on how Medicare will edit NPIs. Once a decision is made to begin requiring NPIs on claims, primary providers i.e., billing, pay-to and rendering providers must be identified by their NPIs or the claims will be rejected once the decision is made as indicated above. Medicare contractors must then use the NPI crosswalk to locate the NPI and associated legacy identifier submitted on the claim for primary providers.

All other providers are considered secondary providers and include referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and "other" providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If the NPI is present for secondary providers, the NPI must only be edited to determine that it has10 digits; begins with 1, 2, 3, or 4 and that the 10th position of the number is a correct check digit.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	N/A (see Provider Education)											

III. PROVIDER EDUCATION TABLE

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**

		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5595.1	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	X	X					

IV. SUPPORTING INFORMATION – N/A

V. CONTACTS

Pre-Implementation Contact(s): Joy Glass 410-786-6125

Post-Implementation Contact(s): Joy Glass

VI. FUNDING

A. *For TITLE XVIII Contractor*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

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

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do 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 specified 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.