

National Provider Identifier (NPI) Application Guidance
For Local Public Health Departments in North Carolina
Provided by the North Carolina Division of Public Health

“Followup Q&A”

November 13, 2006

I. General NPI Q&A:

1. The NPI rule states that the compliance date for all covered entities is May 23, 2007 (except that small health plans that earn less than 5 million dollars in annual revenue do not need to comply until May 23, 2008). Our health department earns less than \$5 million in annual revenue. Does that mean that we don't have to comply until May 23, 2008?

No. Local public health departments (LHDs) in NC do not meet the HIPAA definition of “health plan.” Examples of health plans are: Medicare, Medicaid, health insurance companies, Veteran's health benefits programs, CHAMPUS, etc.

LHDs in North Carolina fall into the category of health care providers who transmit any health information in electronic form in connection with a standard transaction as required by the HIPAA EDI Rule. All health departments in North Carolina must comply with the NPI Rule by May 23, 2007.

2. Are taxonomy codes something new? We have not heard of these codes before.

No. Taxonomy codes have been around for quite some time. Prior to NPI, local public health departments have not been affected too much by taxonomy codes; however, their use is now required when applying for organizational and individual NPIs as well as when enrolling in Medicare and Medicaid as being a health care provider who provides and bills for health care services to these health plans.

3. If we contact the NPI Enumerator, will they provide guidance on how NPIs will be used to process Medicaid claims in North Carolina?

No. The NPI Enumerator has nothing to do with how Medicaid claims will be processed in North Carolina or by any other payer of claims for health care services. Individual payers are determining how they will use NPIs and developing their own specific approaches to processing claims. Each individual payer will most likely have their own set of requirements and will provide you with details about how they plan to process claims. This is one of the reasons that different payers are requesting various kinds of information from your agency about your NPI. It can sometimes be confusing because various payers are using the NPIs different ways in their systems to process your claims for payment.

The NPI Enumerator will, however, answer questions relative to the NPI application process and on issues relative to unique identification but cannot, and will not, tell you how and if you should designate subparts.

4. Who is the NPI Enumerator and how to do we contact them?

The Centers for Medicare and Medicaid Services (CMS) has contracted with Fox Systems, Inc., to serve as the NPI Enumerator. They may be contacted in one of three ways:

1. By phone at 1-800-465-3203 (toll free)
2. By email at customerservice@npienumerator.com
3. By mail at NPI Enumerator, PO Box 6059, Fargo, ND 58108-6059

5. Are there any educational tools available on NPI?

Yes. The CMS web site has many educational tools listed on their NPI web page at http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp#TopOfPage. You must scroll down to the bottom of the page to access links to the various educational tools. Power Point presentations are available on “NPI Overview” as well as “Subpart Designation” containing basic information for all health care providers.

The “NPI Viewlet” also listed near the bottom of the web page is a very helpful interactive educational tool and provides information on NPI as well as on the NPI application process. The viewlet focuses on how to apply for organizational and individual NPIs and provides sample snapshots of both kinds of applications and the instructions for completing the applications.

6. Various payers are contacting the health department asking for our NPI. Are we required to have it now? When must we be using the NPI on claims?

Various payers are contacting all providers who submit claims so that they may begin building their crosswalks to match up the legacy numbers with the new NPI numbers as well as taxonomy codes. (See Question #7 for explanation of legacy numbers.) Having the crosswalk will expedite and ensure the proper payment of your claims. NPIs are required to be used effective May 23, 2007; however, payers are now collecting NPIs and matching them with your legacy numbers. (See Question #8 below for more detailed information on the Medicare implementation plan that is being followed by most health care industry payers.) The sooner you have your NPIs and report them along with your legacy numbers to various payers, the sooner you will be able to test some claims and correct any problems with claims submission and/or processing. You don't want to wait until after May 23, 2007, to begin the testing process.

After obtaining your organizational and individual NPIs, you must report the NPIs and the legacy numbers to the various payers to which you submit claims. Your agency is responsible for notifying **any** payer to which your agency submits claims of your NPI numbers, with the exception of HSIS (more about HSIS below). You must notify payers of your Type I-Individual numbers as well as your Type II-Organization numbers and taxonomy codes. Payers need this information in order to build their crosswalks to facilitate a smooth transition for processing and paying your claims. In addition, each payer is building their own crosswalk so reporting your NPIs to one payer will not suffice for another payer. If your agency doesn't notify all your payers, your claims risk not being processed at all-not to speak of not being paid.

HSIS Exception: As of right now, you do **not** need to notify HSIS of your legacy/NPI numbers and taxonomy codes. Negotiations are underway for this information to be obtained elsewhere. It is possible, however, that this requirement may change and, if so, you will be notified as soon as possible.

(Important Note: This does not, however, relieve you of the responsibility of notifying NC DMA of your NPI/legacy numbers and taxonomy codes. Although you are not required to notify HSIS of your NPI/legacy numbers, you **are required** to notify NC DMA of your NPI/legacy numbers and taxonomy codes in order for your numbers to be in the crosswalk.)

Medicaid: To notify NC DMA of your NPIs, go to <http://www.ncdhhs.gov/dma/NPI.htm> and you will find a copy of the Group Reporting Form (for your organization NPIs) and an Individual Form (for your individual NPIs). Follow the instructions on the form that includes where to send the forms for reporting NPIs.

Medicare and other payers: You should contact Medicare and any other payers to which you submit claims and report your organization and individual NPIs and the legacy numbers that crosswalk to the NPIs.

7. What is a “legacy identifier” or “legacy number?”

"Legacy numbers" or "legacy identifiers" are pre-NPI numbers (or identifiers) that are currently assigned to billing providers (organizations and/or individuals) and are currently being used when submitting claim forms to various payers. Legacy identifiers include numbers such as:

- PINs (Provider Identification Numbers) – includes organization and individual numbers
 - Organization Provider Numbers – agency provider numbers assigned from various payers, i.e. Medicare, Medicaid, BC/BS, CHAMPUS/Tricare, State Employees Health Plan, etc.
 - Individual Provider Numbers – individual provider numbers assigned from various payers, i.e. Medicare, Medicaid, BC/BS, CHAMPUS/Tricare, State Employees Health Plan, etc.
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims. (DMERC, or Durable Medical Equipment Regional Carrier, is an insurance company selected by CMS to process durable medical equipment, prosthetics, orthotics and supplies claims for the Medicare program.)

8. If we already have our NPI, when should we be using the NPI on the claims that are submitted for payment?

The Medicare implementation schedule is as follows. (It is important to note that the majority of other payers of claims throughout the health care industry are also following this same schedule.)

- Between May 23, 2005, and January 2, 2006: CMS claims processing systems will accept an existing legacy Medicare number and reject, as unprocessable, any claim that includes only an NPI.
- Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number or an NPI as long as it is accompanied by an existing legacy Medicare number.
- Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number and/or an NPI. This will allow for 6-7 months of provider testing before only an NP will be accepted by the Medicare Program on May 23, 2007.
- Beginning May 23, 2007, CMS systems will only accept an NPI.

As has been noted in previous announcements, CMS plans to begin testing new software that has been developed to use the NPI in the existing claims processing system. Providers have until May 23, 2007, before you are required to submit claims with only an NPI. Until testing is complete, and we are notified, providers are urged to continue to submit claims in one of two ways: 1) use your legacy number on the claims, or 2) use both your legacy number and NPI on the claims.

Until testing of the new software is completed and we are notified the following may occur if you submit claims with only an NPI: 1) your claims may be processed and paid, or 2) claims for which the CMS system is unable to

match the NPI with a legacy number may be rejected and denied and you will then need to re-submit the claim using the appropriate legacy number.

9. Our health department is a “batch” county that uses proprietary software that interfaces with HSIS. What should we do to be sure our software is compliant with the NPI Rule?

Health departments using any proprietary software for billing, whether or not it interfaces with HSIS, should contact their software vendor and inquire about their readiness for the NPI Rule. You should inquire about expected software updates, testing schedules, formats for the new CMS-1500 claim form (or its electronic equivalent), etc.

New requirements, if any, for file layouts for HSIS will be provided to those vendors that presently interface with HSIS as has been done in the past.

II. Organizational Q&A (for Type II NPI Providers):

10. Are local public health departments in NC required to designate subparts?

No. The NPI Rule states that covered organizational health care providers are responsible for determining if they have subparts that need to have NPIs. Determining whether or not to designate subparts is a local agency decision based on all the information available in order to make the best decision for the agency.

Although it is permissible not to designate subparts, it is not recommended. It is recommended, but not required, that subparts be designated for each grouping of provider numbers presently assigned to your agency. (See Question #11 for examples of subparts.)

11. The previous NPI guidance to local public health departments dated 7/24/06 seems to recommend that health departments should designate a subpart for every program within the health department. Is that correct?

No. It is not recommended nor required that subparts be designated for each program within the health department simply because a program exists. The guidance dated 7/24/06 was only meant to provide examples of possible subparts that a health department might want to consider designating. It was meant to point out that having only one organizational provider billing number is not how health departments presently operate. Designating subparts for at least the Medicare and Medicaid provider numbers that you presently have will allow your department's billing and accounts receivable RAs and payments to continue to arrive in the manner in which you are accustomed. It will also allow various payers to crosswalk your legacy provider numbers with your NPI provider numbers to expedite the processing and payment of your claims.

If your agency chooses to designate additional subparts, it is permissible to do so; however, it is not recommended that your agency designate a subpart for each program within the health department simply because you have separate programs. Think through your billing process prior to making these decisions.

In addition, U.S. DHHS does believe an NPI needs to be assigned to every address at which a service can be provided; therefore, an NPI may or may not be assigned to a requested designated subpart that was submitted on your application. The criteria used by the enumerator is based on the NPI Rule and guidance from CMS.

Below are examples of subparts that may exist within a local public health department.

Example #1:

The Home Health agency may presently have the following assigned legacy provider numbers:
Medicare, Medicaid, NC BCBS, Champus, Tri-Care Health, etc.

Home Health would be designated as a subpart and these legacy provider numbers will equal one NPI number after the NPI number is assigned – not because it is a separate program, but because it has a separate set of legacy provider numbers.

Example #2:

The Health Department may presently have the following legacy provider numbers assigned to the “over all” agency, meaning that the numbers are not presently assigned to any specific program or group of services but to the entire agency: Medicare, Medicaid, NC BCBS, etc.

The health department would be designated as the primary provider location (or the “parent” organization) and the legacy numbers will equal one NPI number after the NPI number is assigned. In this example, although the NPI is applied for in a similar way, it is not really a subpart, but the main number for the overall agency.

Example #3:

The Health Department may presently have a legacy Medicaid provider number presently assigned to its Family Planning/Child Health programs which is used to bill specifically for these services.

Family Planning/Child Health services would be designated as a subpart, with the Health Department listed as the primary location and parent organization. (FP/CH would be designated as a subpart because there is a separate Medicaid number, not because it is a separate program.) The legacy Medicaid number will equal the new NPI number after the NPI number is assigned.

Example #4:

The Health Department may presently have a legacy Medicare, Medicaid, NC BCBS provider that it uses to bill specifically for flu/pneumonia services.

“Mass Immunization Services” would be designated as a subpart, with the Health Department listed as the primary location and parent organization. (Mass Immunization Services would be designated as a subpart because there is a separate group of existing legacy numbers for this service, not because it is a separate program.) The legacy numbers will equal the new NPI number after the NPI number is assigned.

12. Are health departments required to designate a subpart for the CLIA lab?

As explained in Questions #10 and #11, health departments are not required to designate subparts; however, it is recommended.

If your health department bills for laboratory services only via HSIS as part of bundled, or un-bundled, services, at the present time, you do not need to designate the laboratory as a subpart. If, however, your health department bills for laboratory services to any payer other than via HSIS, it is recommended that the laboratory be designated as a subpart.

13. Our health department is considering applying for only one Type II organizational NPI for our agency and not designating subparts. Is this permissible?

Yes, it is permissible; however, it is not recommended. It is recommended, but not required, that subparts be designated for each grouping of provider numbers presently assigned to your agency.

14. If our health department decides not to designate subparts how will this affect the crosswalk and how will it affect the processing of our claims?

If all existing legacy provider numbers (or grouping of numbers) assigned to your agency have been reported when applying for NPIs with the enumerator and then reported to various payers, there should be no problems with claims processing. All the legacy numbers will be matched on the crosswalks with the new NPI number if you report them. (See Question #6 for information on how to report your NPIs to various payers.)

It is extremely important that each legacy number (or grouping of numbers) presently assigned to your agency be accounted for in the payer's crosswalk with either an NPI number or be de-activated in the payer's files. If not, after May 23, 2007, claims submitted with an un-accounted for legacy number cannot be processed or identified.

15. If our health department has assigned legacy numbers that we no longer use for billing, should we deactivate our Medicare and Medicaid numbers and how should we go about doing so?

If your agency is absolutely sure that there are legacy numbers no longer used for billing, you should not apply for an NPI for these legacy numbers. Your agency must contact each specific payer that assigned the legacy number and inquire about de-activating the legacy number that is no longer used.

III. Individual Q&A (for Type I Provider NPIs):

16. Should health departments apply for NPIs for all registered nurses, FNPs, PAs, social workers, etc, within the department?

The guidance dated 7/24/06 (distributed 8/9/06) recommended that all registered nurses, PAs, social workers, etc., within the health department apply for NPIs as these numbers may be needed for various reasons, primarily for entering their NPIs on a CMS-1500 claim form (or its electronic equivalent). After contacting CIGNA Medicare, NC Blue Cross/Blue Shield, and reviewing other HIPAA documentation, **that recommendation is now being revised.**

Until further notice, it is recommended that you only apply, or require your individual staff to apply, for NPIs for the following:

1. licensed staff physicians (those actually employed by the local public health department) and,
2. licensed clinical social workers employed by the health departments that provide Behavioral Health Services,
3. licensed dentists
4. certified nurse midwife (CNM)
5. FNPs, PAs, NPs (whether or not these individuals possess a Master's Degree)
6. any other provider whose name/NPI and/or legacy provider number would presently be entered on a CMS-1500 claim form (or its electronic equivalent), i.e., contract physicians, etc.

This does not include other providers that may be entered on an encounter screen in HSIS for services that may be billed only through HSIS (i.e., CSC, MCC, MOW, etc.) It is not recommended, at this time, to obtain NPIs for:

1. Registered Nurses
2. Un-licensed social workers
3. Lab Technicians

§ 106-103 defines a health care provider as a provider of medical or health services, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business and the NPI Rule states that all health care providers are eligible for NPIs. All health care providers who are HIPAA covered entities, whether they are individuals or organizations, are required to obtain an NPI to identify themselves in HIPAA standard transactions.

When billing via HSIS: Health departments in NC presently bill for certain services via HSIS that are only reimbursable by Medicaid and do not require a physician's provider number but require a registered nurse's (or other specifically credentialed provider's) provider number. These services include CSC, MCC, MOW, etc. Negotiations are presently underway to avoid a change in this requirement. It is important to note, however, that it may be a future requirement to obtain an NPI for these providers. If there are changes to this requirement, you will be notified and you may then obtain the appropriate NPIs.

If you have already obtained NPIs for the above mentioned providers, it's okay because any health care provider as defined in § 106.103 is eligible to receive an NPI. If you have not obtained NPIs for these specific providers, you may want to wait until further information is available before requiring NPIs for registered nurses, un-licensed social workers, etc. There are still many unanswered questions relative to the use of NPIs and everyone nationwide is learning as we proceed through this process.

When billing any other payer: When billing other payers (Medicare, private insurance, Medicaid billing directly to EDS, etc.), covered entities **must** enter the NPI/legacy number of the physician providing the service or the supervising physician of the FNP, NP, PA, RN, etc., in order for the claims to be processed and paid.

The only circumstance in which Medicare would process and pay a claim without the physician/supervising physician's NPI/legacy number is if the service was provided by a FNP, NP, or PA who has a Master's Degree. The FNP, NP, or PA would also be required to be enrolled by CIGNA Medicare as a Medicare provider of service prior to filing claims.

Payers other than Medicare (NC BC/BS, Medicaid, private insurance) will not process/pay claims without the NPI/legacy number of the physician, or supervising physician, who provided the service.

If you have further questions relative to applying for NPIs and other HIPAA related information, please contact Frances Taylor, HIPAA Liaison to Local Public Health Departments, at 919-715-3358 (HIPAA Hotline) or email frances.q.taylor@ncmail.net.