Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
SUBCOMMITTEE ON STANDARDS, AND SECURITY

October 11, 2006

From:

The Workgroup for Electronic Data Interchange (WEDI)

Presented by:

James D. Whicker
And
Gail Kocher

Mr. Chairman and members of the sub-committee, I am Jim Whicker, Chair-elect of the Workgroup for Electronic Data Interchange and I thank you for the opportunity to speak with you today on behalf of WEDI regarding the National Provider Identifier (NPI). By way of information, I also serve as EDI Liaison for AAHAM, an organization of provider patient financial services professionals and am currently employed as Director of EDI for Intermountain Healthcare.

Following my comments, Gail Kocher who is a Technical Business Analyst in the HIPAA Knowledge Center for Highmark, Inc., Co Chair of WEDI's National Provider Identifier Outreach Initiative (NPIOI) and the NPI Subject Matter Expert liaison from ASC X12 to WEDI, will be providing information regarding the results of the WEDI Readiness Survey and the NPI forum WEDI conducted in August.

WEDI presented a comprehensive report on NPI at the July NCVHS Subcommittee meeting. We will not attempt to cover all that information again today, but we would like to focus our comments on a few significant issues related to NPI.

On September 6th, 2006 WEDI met with several individuals from CMS, including representatives from OESS. The agenda for the meeting was focused on the National Provider Identifier (NPI). Discussion was based on feedback received by WEDI during the NPI Hearing. Discussion topics included:

- Overall industry readiness
- The NPI dissemination notice
- Challenges with the current deadline and dual use
- Coordination of outreach activities.

It was a productive meeting and all topics covered in that meeting are addressed in detail in the following discussion.

During the CMS meeting, WEDI suggested that there be an industry summit for health plans to discuss the options surrounding adoption and use of the NPI, and gauge from that sector of the industry as to what the state of the industry is. CMS supported the concept, and WEDI will be proceeding with scheduling this summit as soon as is feasible.

The following are the issues WEDI would like to address as key topics to consider in order to have a successful implementation of NPI.

1. There appears to be a lack of understanding of basic NPI tenets. There is a need to expand NPI Outreach to both the payer and provider community. The frequency and urgency of messages is critical. WEDI is committed to providing education to the industry. The support and presence of CMS payer and regulatory staff provides the draw needed to get those who need the information to the table. The message that needs to be sent includes:

    a. NPI 101. There is a need for basic education about the NPI. For example, frequent questions heard are “Can one NPI cross two Tax ID numbers” or “Can a physician have more than one number?” We need to have the ability to push that information closer to the provider. A CMS conference call was held on September 26. Thousands of attendees dialed in, and many more were unable to participate as the number of phone lines available was exhausted. This shows the huge need for information. This type of format, with that many participants, cannot deliver the messages that the individual provider office or hospital appears to need.
    b. What goes in must come out. This message needs to be delivered to help payers and providers understand the relationship of the ‘billing provider’ (and under the 4010 transaction the “pay-to” provider as well) and its relationship to the ‘payee’ in the 835. This ensures that the right provider NPI gets the right payment for the right amount. There are Medicare Crossover and Coordination of Benefit (COB) implications when receivers are not capable of using

the identifier, whether legacy or NPI, that is crossed. The Implementation guides were written long before the NPI rule was written. The guide authors tried to anticipate the needs, and additional education about the intent of the transactions is needed to head off problems down the road.

c. Many providers do not fully understand the usage or meaning of Health Care Provider Taxonomy codes. With the recent mandate by Medicare to use them on institutional claims, there is a need for answers to questions about usage of taxonomy and its relationship to NPI. Providers need to know how payers (mainly Medicare) will use it to apply payment methodologies to help them determine their enumeration strategy, and other payers need to understand it for crossover purposes.

d. It's critical that more information be presented and supported from CMS in its role as regulator. Information from CMS as a payer is received as such, and many in the industry question how (or if) that information can or should be applied to other segments of the industry. One of the most common requests for information centers around unresolved issues and questions around subparts. Medicare has shared a significant amount of information about their data needs, but providers still do not understand the Subpart issues sufficiently. Information to help them make intelligent enumeration decisions is needed.

2. Lack of NPI/NPPES Dissemination

As a result of the NPI Hearing, WEDI recommended that CMS issue the NPI Dissemination Notice and have in operation a dissemination system by June 15, 2006. This date was agreed upon by the participants in the hearing as to the latest date dissemination should be made available so as to not impact the successful implementation of NPI. As of today, we do not have a dissemination notice.

Access to NPPES Data is part of the overall NPI Dissemination process needed to successfully achieve industry compliance. Generally speaking, data can be obtained from two main sources: the providers themselves and in the future from the NPPES system.

The following are some of the most significant needs for accessing the NPPES data:

- Payers and clearinghouses need the NPI now in order to (among other things):
    a. Perform NPI Verification: confirming that an NPI they already received from a provider is indeed the right NPI that belongs to and identifies that provider
    b. Populate their large internal provider databases

c. Build, establish, and test their internal crosswalks
d. Begin using the NPI in outgoing claim payment transactions
e. Begin using the NPI in coordination of benefits with other payers

- Among other things, a health care provider needs the NPI of other providers now, in order to:
  a. Perform NPI Verification of other providers (referring, ordering, etc.)
  b. Populate their internal databases of 'external' provider NPIs.
  c. Test the use of these 'external' provider NPIs in electronic transactions with payers
- Billing services and others need the NPI of providers to support their clients' needs for appropriately billing payers with those NPIs.
- All will need to obtain data from NPPES frequently to make sure new NPI data is obtained. Particularly, in the coming months when the database will ramp-up significantly with new applications coming in at a rate of several thousand a week.

- All parties need access to NPPES data to identify which of their trading partner providers have NPIs and which do not, so they can effectively target their outreach efforts--- "sharing" the NPIs for those who have them---applying for NPIs for those who do not.

<u>It is critical that the NPI dissemination policy be released immediately.</u> WEDI urges NCVHS to work with CMS to release the policy as quickly as possible. Many organizations are considering utilizing Data Use Agreements. We are hopeful that meeting the needs of these requests does not detract from issuance of the dissemination policy.

3. <u>Delays in provider enumeration (both individual providers as well as organization providers) are of great concern</u>.
   a. Statistics from the NPPES enumeration process show great strides in enrollment of providers. However, the real issue is not the number of providers enrolled, but the number who have shared that NPI with their payers, and the payers who have implemented those numbers into their systems. Gail Kocher will speak on this topic in more detail.
   b. Anecdotal information indicates that a statistically insignificant number of transactions between trading partners have actually used NPI. Those transactions sent with NPI, are mostly claims. Few, if any, payment, status, or eligibility transactions have been tested between payer and provider to validate the implementation of NPI correctly. The critical issue is not who HAS an NPI. It is how those that have them are USING them.
   c. Concerns have also been expressed about the downtime selected for maintenance of the NPPES system. Downtimes have usually

been during standard business hours, and often for a significant period of time, e.g. entire business days. In addition, industry reports indicate paper applications take 4 – 6 weeks and sometimes as long as 9 weeks, to process. As we move closer to the critical May date, this will become a much larger issue that may impede provider enrollment.

4. NPI Testing. Successful testing of NPI transactions is at risk for many reasons:
    a. Providers have experienced a significant amount of delay, mostly due to their lack of understanding of the Type II concept and their being able to make strategic decisions in how they wanted to enumerate for Type II NPI's.
    b. Providers are still reporting that in many cases, vendor supplied billing systems still need to be modified to handle the NPI.
    c. The industry is still waiting for a dissemination rule in order to finalize the processes they intend to put in place to collect, validate, create crosswalks, etc.
    d. Provider and payer IT resources are involved in other projects such as changing to the new 1500 claim form and the UB04 claim form.
    e. Payers are requesting proprietary methods of communicating NPI data for cross walk building rather than use the recommended methods suggested by our WEDI white papers. These documents had the intent to standardize the sharing of NPI information from provider to payer until the NPPES system was operational. The lack of usage of these recommended information exchange processes, and the lack of a functioning dissemination process, is creating an administrative burden on both payers and providers. WEDI recommends that CMS, as NPI regulator, assist in providing education and encouragement to utilize those tools and to expedite the release of the dissemination policy.

These delays, as well as the number of trading partners that are just not ready to test, brings the industry to a very short time frame now to move transactions back and forth to ensure smooth migration from legacy only transactions, to dual use NPI and legacy transactions, and finally to full NPI usage.

CMS, as a large payer organization, has had access to the NPPES data via a Data Use Agreement and seems to be ahead of the industry in its preparation. They are also able to gather NPI's through enrollment forms providers are required to complete. Another example is access that Medicare Contractors have to electronic file interchange or EFI organizations, and information about NPI's assigned through that process. These sources of information are not available to other covered entities.

Access to this information has provided an advantage to CMS that others in the industry, who desperately need the information, do not have.

It is important however, to note that we have heard concerns expressed that Medicare does not have the kinks worked out of their NPI crosswalk. As such, providers face rejections of claims – even though both the NPI and the Legacy number on the claim would be correct.

5. Concerning Covered Entity Readiness. Data and anecdotal information that we have access to tell us that not all payers and providers will be ready on May 23, 2007. Payers and providers need to consider what plans they will put in place should a trading partner or vendor fail to be ready in time to test and validate prior to or after May 23, 2007. They need to consider what post implementation strategy is needed should they find out that claims and payments are not being processed as expected. Gail will review the results of the readiness survey and discuss some statistics that we believe represent actual usage of NPI in transactions.

   The WEDI Hearing and subsequent WEDI letter to Secretary Leavitt recommended the following:

   Recommendation: That CMS allows the dual reporting of NPIs and legacy IDs after the deadline of May 23, 2007 for a minimum of 6 months. The need for more than 6 months should be determined through a status check of the industry readiness in November 2006. Failure to allow such an extension would exacerbate and prolong the period of non-compliance.

   This recommended 6-months period is a transitional period, where NPI is required in all transactions, but legacy ID's are allowed concurrently as secondary IDs. This should not be perceived by the industry as a delay in the NPI implementation by May 23, 2007. Providers must still have completed their NPI enumeration by the deadline. Systems remediation must have also been completed. Health plans must still be capable of processing NPI transactions. **Extending the Dual Use period is only intended to allow trading partners to address NPI crosswalk, mapping, and reimbursement issues.**

   As of this date, the WEDI position on this recommended 6 month dual usage transitional period extension has not changed. WEDI is in the process of conducting a 'status check' of the industry for November to determine if there is a need to recommend an extension beyond 6 months. We believe that the signs in the industry are showing us that many entities have a significant amount of work to complete to ensure claims and payments continue flowing electronically after May 23, 2007.

Many state Medicaid operations have already informed providers that they will not make the May 2007 deadline. Any provider that submits claims to those organizations will need to have the dual capability long after the May 2007 deadline in order to keep claims and payments flowing.

I would now like to turn the time over to Gail Kocher. This will conclude my prepared remarks.

Thank you Jim. Mr. Chairman and members of the sub-committee. I am Gail Kocher, testifying on behalf of WEDI. I am a Co Chair of WEDI's National Provider Identifier Outreach Initiative (NPIOI) and the NPI Subject Matter Expert liaison from ASC X12 to WEDI. For informational purposes, I am also a Technical Business Analyst in the HIPAA Knowledge Center for Highmark, Inc. I would like to thank you for the opportunity to present testimony regarding the National Provider Identifier or NPI.

6. Industry readiness Survey Conducted May 2006. WEDI NPIOI conducted an industry readiness survey in May 2006. I will address the highlights of the results, many of which identified the need for additional data collection this year...

   This survey asked whether respondents had established an overall NPI Project Plan. Only a small percentage of providers had established or were in the process of establishing a plan (9%), 80% of Payers had or were in the process and 58% of providers indicated they had no plan in place. WEDI NPIOI continues to pursue education and outreach, often in conjunction with CMS, in an effort to bring full awareness of NPI to the provider community, as well as other stakeholders. *(Figure 1, Slides 4-7)*

   Survey participants were also asked where they were in their project. At approximately one year prior to the mandate date, a very small percentage of the industry had implemented. Many providers and payers were still in early phases of the project process or could not even provide a response to the question. *(Figure 2, Slides 12-15)* The State Medicaids met in late September and information coming out of that meeting indicated that approximately one-third of the Medicaids will absolutely not be ready on May 23, 2007 for NPI only. Another third are planning to be ready, but reports are that many of those will not meet the deadline either. If the industry reaches a point where some have implemented to NPI-only and others cannot do business without a legacy ID, additional impacts will result, especially in the coordination of benefits transaction environment. If secondary payers receive only NPI on crossover claim files and they cannot process NPI-only, the claims process will fail. Providers' account receivables will likely suffer. At that point, providers are faced with either sending secondary claims on their own, often resulting in additional costs

when using clearinghouses, or they will bill patients and expect the health care consumer to pursue reimbursement from the other payer.

The ability to conduct NPI-only claims is a significant measure of industry readiness. Only one quarter of payers and providers will be ready for NPI-only claims prior to the first quarter of 2007. Many of the payers that can receive NPI only claims late in 2006 are requesting that providers continue to send legacy IDs even when they are NPI only ready. Both of these occurrences limit the testing time available to all stakeholders. The available time to react to any issues identified when entities actually move to NPI only becomes very limited. *(Figure 4, Slides 18-21)*

Survey participants were also questioned on the guidance CMS and WEDI have made available to date. We found that this guidance is not meeting the expectations of the industry. There are still many unanswered questions in the minds of the industry. Continued education and outreach needs to be provided jointly by CMS and WEDI. Key topics that are missing continue to be subparts and dissemination. *(Figure 3, Slides 16-17)*

Let me now discuss some questions that are specific to the provider community. Providers were asked whether they will subpart their organization, and whether they are sending NPIs on claim transactions as of May 2006. The results clearly show that the industry is still waiting for additional clarification and information. Many have not decided or do not understand enough to determine their enumeration schema, which undoubtedly impacts when they will begin using their NPI(s) in the transactions. *(Figure 5, Slide 24)* The use of NPI(s) in transactions is also a factor of providers having information available from all their payers as to their payers' timelines so they can incorporate this information in their own planning and implementations. *(Figure 6, Slide 26)*

Let me now discuss some questions that are specific to payers and clearinghouses, primary receivers of the HIPAA transactions in which the NPI will be mandated. Some in the industry are taking a crosswalk approach that can be attributed to many factors, e.g. atypical providers will not be issued NPIs or a national ID, so legacy enumerations will still need to be in place. The costs associated with converting legacy systems to NPI only were significant (estimates of ~$20 million for large health plans) due to the complexity and logic behind health plan legacy enumeration identifying things such as contracting and pricing arrangements. *(Figure 7, Slides 27-28)*

Many are still working out data collection strategies, especially since the data dissemination notice is as yet unpublished. The low percentage for NPPES, we believe, is due to lack of dissemination information, which has

forced many to forge ahead and prepare alternatives. Lack of data dissemination likely plays a role as well with respect to provider re-enrollment requirements. Payers and clearinghouses are still undetermined as to the best approach of obtaining provider NPIs. *(Figures 8-9, Slides 29-30)*

Again, the uncertainty of whether entities will be able to access NPPES to collect NPIs and/or conduct primary source verification, has delayed decision making on the approach to what validation/verification is needed in an operational environment. *(Figure 10, Slides 35-36)*

At the time of the survey, neither of the paper claim forms that undergo OMB approval had been approved, and we believe that the industry was waiting for confirmation that the forms would be available with the time allowance that is required to implement the paper forms with NPI. While OMB approval is not required for any other payer than Medicare, many payers in the industry follow Medicare's lead in terms of implementation so as to limit the differences in requirements placed on the provider community. *(Figure 11, Slides 40-41)*

Vendors are integral to NPI implementation, and there were some questions specific to vendors. There is still the possibility of over half of the direct billers having to pay to obtain the needed upgrades for NPI. Payment requirements may impact when clients do upgrades due to availability of funds, especially if they did not plan for a cost to their upgrade. Such costs may cause delays that impact testing by decreasing the available time. *(Figure 12, Slide 43)* Providers that are required to use NPIs on paper claims by a payer may be impacted if their practice management system is not upgraded by the vendor, or they do not know until late in the time frame before May 23, 2007, whether it will be upgraded or not. *(Figure 12, Slide 44)*

There are several transaction issues that continue to cause concern to the industry, one of which is the 835 Claim Payment transaction. Providers need to understand what they can expect to receive in order to coordinate with their vendors and clearinghouses when applicable, but 61% of payers did not respond to whether or not they will return NPIs or legacy IDs on the 835.

There has been much discussion recently on the 835 and how it is to be implemented. ASC X12 is currently processing some HIPAA Interpretations through their portal that address this issue. As outlined during a session at the recent X12 trimester meeting, the intent is to return the Billing Provider NPI in the Payee segment (N1) where the tax identification number (TIN) is returned today. The TIN moves to the Payee Additional Identification (REF) segment within the Payee Loop, and a

legacy ID can still be sent in a second iteration of the REF segment through May 22, 2007. Claims may be bulked to a mutually agreed upon provider entity NPI, but the NPIs submitted on the claims must still be returned in the 835 in the Provider Summary Information (TS3) segment.

Adding to the confusion is the Medicare implementation plan as identified in Change Request 5081, which states that as of October 2, 2006, Medicare will start sending NPIs on the 835. The NPI will not be sent at the Payee level, however, it will be sent only at the Claim or Service level, which is intended to identify the Rendering Provider.

Providers need to understand what to expect due to the many impacts they face. Medicare's approach leaves providers and vendors with no ability to test prior to May 23, 2007 for the claim payment transaction they will receive from Medicare. For applications that look to the provider ID in the Payee segment for posting or reporting, there is no ability to test that the returned 835 can be matched up to their claims data since the NPI is being returned in a different location than will occur after the mandated date. Providers depend on remittance data for claim resolution and/or payment. There are many concerns over how the data will be returned and bundled. These concerns stem from the availability of data elements used on an inbound 837 to crosswalk which are not available on the 835. Provider account receivables changing drastically due to unexpected claim payment data or last minute changes without testing capabilities is of significant concern to the industry. The high percentage of no responses to this question highlights that this is an issue that needs to be addressed from an educational perspective quickly so that payers will be able to implement with their trading partners as soon as possible, rather than waiting until May 23, 2007.

Finally, let me offer some general summary conclusions and observations. The survey included strong provider participation with 69% of the total respondents (635). Payers were the next contingent at 21%, with clearinghouses and vendors making up the remaining 10%. The respondents did not answer many of the questions, leading to the conclusion that a lot of organizations were not far enough along in their processes to even provide an answer. There were, however, enough responses within each question to conduct an analysis. Additional surveys are needed to gauge industry readiness going forward, and WEDI NPIOI released a second survey the first week of October. The survey questions were streamlined for ease of response. Additional content questions and clarification of content in some existing questions were undertaken as well.

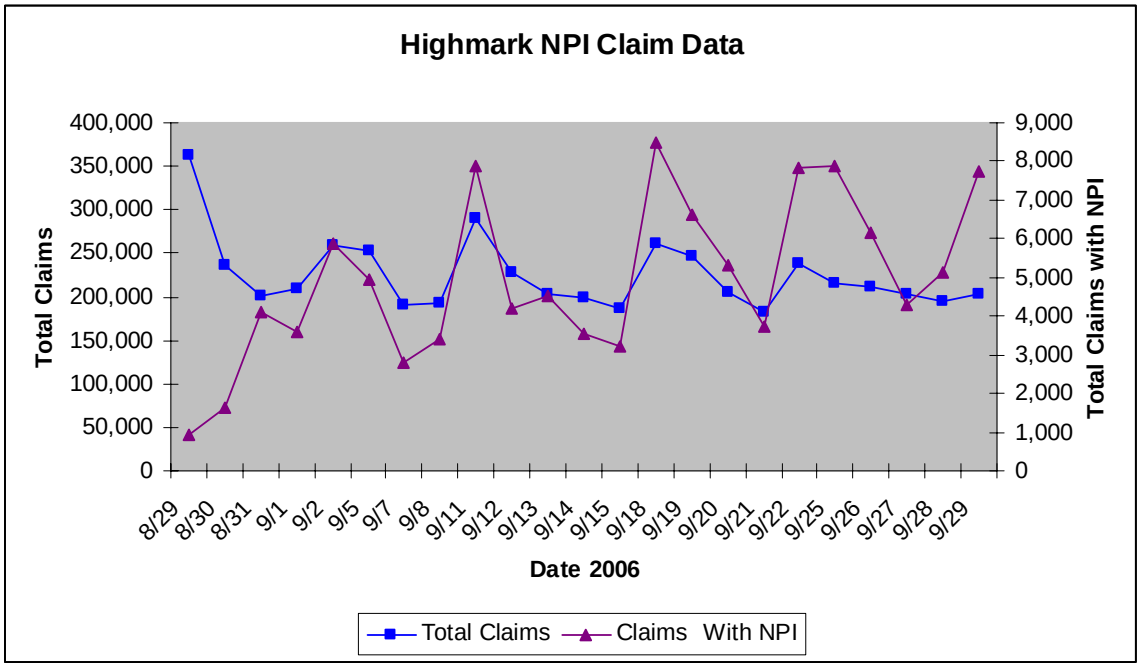
7. WEDI NPIOI August 2006 Forum Observations – WEDI NPIOI held its 4th NPI Industry Forum in August of this year. Given the attendance of 185 stakeholders, it was evident that NPI is still a very significant issue for the industry. The open forum style sessions brought together Providers, Payers, Clearinghouses/Billing Services, and Practice Management Vendors to discuss a variety of NPI related topics, e.g. case studies of enumeration, including Electronic File Interchange (EFI), NPI cross-walking, and the use of taxonomy codes for subparts. We observed that the industry's transition is occurring at a disparate rate. Earlier NPIOI forums had audience bases that were on a more equal knowledge level. This forum found some in the audience brand new to NPI and others at end-stage implementation points. This points to the continued need for education at the 101 level while also working with those farther along to educate based on lessons learned.

   WEDI NPIOI is continuing to work to educate the diverse audience by developing a NPI 101 Audiocast in advance of the November Fall Conference, and is developing a 101 toolkit. WEDI NPIOI is also conducting a series of Early Adopters Audiocasts from various stakeholder perspectives to make available their lessons learned for others a step or two behind in their implementations.

8. NPPES Enumeration Statistics Mismatch to Actual Provider Reporting and Transactional Usage with Payers: As of 10/04/2006, a total of 1,234,910 NPIs were issued. The statistics only break down Type 1 Individual vs. Type 2 Organizational. Health plans often track providers by Provider Type and Specialty, so the high-level breakout of data is difficult to compare to health plan data to get a true picture of where the industry is with respect to enumeration. Industry planning, transition, and implementation would be better served with weekly reports of the number of NPIs issued. Reports that break out the numbers by NPI Type (1, 2) provider type (e.g. M.D., D.O., D.M.D.) and provider taxonomy would facilitate stakeholder analysis of their status of NPI information exchange, and data collection versus NPIs issued.

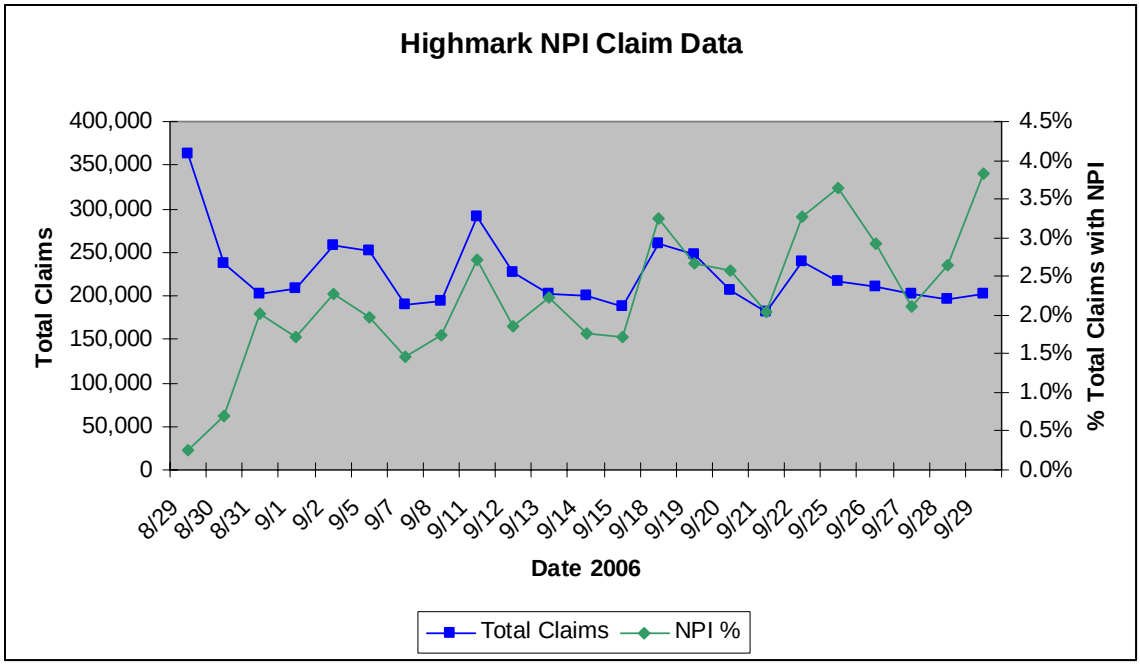
   CMS estimates were that ~2.5 million providers would need NPIs, but there is concern that the estimate did not account for subpart enumeration or ancillary and allied health care provider types. For example, the following are the NPIs issued to Pennsylvania Providers: Type 1 = 50,610, Type 2 = 14,127 for a total of 64,737. In contrast, as of 10/02/2006 based on providers on record, the following numbers of NPIs were reported to Highmark: Type 1 = 22,507 out of 59,762 (37.7%) and Type 2 = 5,286 out of 45,324 (11.7%). This is a total of 27,793 NPIs out of a total provider universe of 105,086 (26.4%). Highmark is the largest health insurer in Pennsylvania based on membership, and one of the largest health insurers in the U.S.

The actual usage of NPIs in transactions is significantly less than the number issued. For example, from 08/29/2006 through 09/29/2006, Highmark received 5,171,884 claims electronically (837 Institutional and 837 Professional), of which 113,756 claims had an NPI in at least one of the provider loops.



Please note that the graph had to be adjusted in order to actually show a line for claims with NPI. If the chart had used the same axis for both series of data, the line for claims with NPI would be an almost negligible line across the bottom of the graph.

This is only 2.2% of claims with an NPI on average.



Providers are still uncertain as to what they need to do with their NPIs once they have obtained them. Many believe that their health plans will have access to NPPES as was available for UPINs. Concern over requests to provide copies of NPPES notification as audit trail documentation that an NPI was issued by NPPES exist today. Mixed messages from Payers about whether or not to report across the industry is also confusing to providers. Providers are hearing that carriers and FIs do not need them to report as they have access to NPPES. Providers extrapolate FI/Carrier NPPES access to their other Payers as well. Other Payers continue to request NPIs from Providers in a variety of formats and documentation requirements.

9. The 837 inbound claim transaction concern. As of October 2, 2006, claims are being rejected by Medicare when submitted with NPI only, or NPI and Medicare legacy ID where the NPI is not found on the Medicare Provider Identifier crosswalk. This applies to Billing, Pay-To, and Rendering Providers and Secondary Provider IDs when a Medicare Legacy Provider ID is sent. Some other Payers have taken the same approach, and other Payers have taken the approach to attempt to translate the NPI to legacy ID, but if it does not match the legacy ID submitted on the claim, continue processing with the legacy ID. These dual strategy differences ultimately impact how and when providers implement, based upon their own systems capabilities.

This concludes my prepared remarks. I would like to thank the sub-committee for the opportunity to present this testimony. Jim and I would be pleased to respond to any questions or points of clarification that you might have.