Time to Apply for a National Provider Identifier

Less than six months remain until the May 23, 2007, National Provider Identifier (NPI) compliance date; at which time physicians, other health care professionals and payers are expected to be using NPIs in connection with the electronic transmission of all transactions covered by HIPAA.

Electronic transmissions include all media (such as magnetic tape, disks and CDs), the Internet, extranets, leased lines, dial-up lines and private networks. With the compliance date quickly approaching, now is the time for health care providers and payers to apply for, secure and begin using NPIs, or risk experiencing delays in payment or denial of reimbursement for some claims. Accordingly, the Centers for Medicare and Medicaid Services (CMS) have adopted the slogan: “Getting an NPI is free – not having one can be costly.”

The NPI is a unique identification number for health care providers that will be used by all health plans. Anyone who uses standard electronic transactions, such as electronic claims, eligibility verifications, claims status inquiries and/or claim attachments, will be required to include NPIs on electronic transactions no later than the compliance date. This includes physicians and other practitioners; physician/practitioner groups; institutions such as hospitals, laboratories, and nursing homes; organizations such as health maintenance organizations; and suppliers such as pharmacies and medical supply companies. This does not include health industry workers, such as admissions and billing personnel, housekeeping staff and orderlies, who support the provision of health care but do not provide health care services.

Section 1173 of the HIPAA Administrative Simplification regulations mandated the adoption of “a standard unique health identifier for each individual employer, health plan, and health care provider for use in the health care system.” The stated purpose of this mandate is to improve the efficiency and effectiveness of the electronic transmission of health information. Historically, health plans have assigned identification numbers to each health care provider with whom they conduct electronic business. Providers who do business with multiple health plans have multiple identification numbers assigned by different plans, and frequently, even within the same health plan. Employers, providers, payers, clearinghouses, patients and vendors...
experience unnecessary confusion, higher costs, increased workload and processing delays as a result. The NPI is intended to alleviate these problems by ensuring that each provider has only one unique identifier to be used in transactions with all health plans.

Securing an NPI is a straightforward and convenient process. Follow-up tasks – which include updating internal billing systems, coordinating with billing services, vendors and clearinghouses, and testing the system with payers – are estimated to take 120 days. Health care providers apply for an NPI by using one of the following methods: (1) apply online at https://nppes.cms.hhs.gov/; (2) call the NPI enumerator at (800)-465-3203 and request a paper application to complete and mail back; or (3) grant permission to a CMS-approved electronic file interchange organization to obtain an NPI for the health care provider. The application form will require certain personal information, including Social Security numbers from individual health care professionals, federal employer identification numbers and any other identifiers that health care providers have with Medicare or private insurers.

Despite the relative ease of applying for and implementing NPIs, there is some reluctance by health care professionals to get them. For example, the American Medical Association (AMA) has expressed concern about the lack of CMS guidance regarding how personal information associated with the NPI will be accessed and controlled. Consequently, the AMA has requested that CMS remove the Social Security number requirement from claims forms.

Similarly, the Workgroup for Electronic Data Interchange (WEDI) has requested that CMS implement a contingency plan to allow the health care industry to use old identification numbers for at least 12 months beyond the deadline. This request was made after a WEDI survey in October 2006 that indicated that many health care professionals and payers have been delayed in completing the follow-up tasks required to use NPIs by the compliance date. WEDI argues that the health care industry has underestimated the level of work required to implement the NPI. CMS has not yet responded to the AMA’s request, but has agreed to consider WEDI’s request for a year-long extension of the deadline as part of its review process.

Notwithstanding the concerns expressed by the AMA and WEDI, and in light of the quickly approaching compliance date, health care professionals should not delay in applying for NPIs. After the initial burden of securing an NPI and completing the follow-up tasks, health care professionals may experience more effective and efficient processing and simpler electronic transmission of data.

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Still Have Questions About the DRA? We’ve Got Answers

In the December 2006 Health Law Alert, we noted that the Centers for Medicare and Medicaid Services (CMS) finally issued long-awaited guidance on Deficit Reduction Act (DRA) Section 6032. Section 6032 requires entities that make or receive at least $5 million in annual Medicaid payments to establish written policies and procedures designed to educate their employees, contractors and agents about federal and state false claims laws and whistleblower protections.

As previously mentioned, the guidance did not provide much direction regarding the development or contents of a policy, and it does not change any of the basic requirements for complying with Section 6032’s provisions.

To help our clients understand the new DRA guidance better, we’ve prepared a list of questions and answers based on CMS guidance that may offer assistance, including information on definitions, policy distribution and other topics.

As always, if you have any questions or require additional clarification, please contact any member of our Health Care Services Practice Group, and we’ll be happy to assist you.

Additional Guidance on the Definition of Agents and Contractors

Q: Is an attending physician considered a contractor or agent of a long term care nursing home?

A: This depends on who pays the physician and whether there is any sort of contractual agreement. If the entity does not pay the physician and there is no contractual agreement with the nursing home then the physician likely is not a contractor or agent. If the entity does pay the physician, then the physician would be considered to be an agent.

Q: Does the definition include supply vendors who supply products that may be used on a patient that may be paid for services rendered with Medicaid funds?

A: Yes, if they are providing health care item supplies.

Q: In the case of a university that has a separate health sciences campus, must all contractors on the entire campus be included or just those on the health sciences campus?

A: Just the contractors on the health care sciences campus must be included. There would be no need to get non-health sciences persons involved.

Q: Are medical supply companies that just drop off materials (i.e. bandages, medical tape, etc.) that the entity then bills for, included in the DRA education requirements?

A: Yes if they have a contractual agreement with the entity. Most likely the answer is yes even if there is no a contract in place because they are providing health care items to Medicaid patients. CMS will look into this in more depth.

Q: Are those involved in monitoring of health care included?

A: No guidance provided.

Q: If the entity contracts with a group purchasing cooperative that negotiates prices with national vendors and does not have any direct contract with the
manufacturer, are the individual vendors considered contractors for the purposes of DRA?

A: CMS will take into consideration and issue more guidance.

Distribution of the Policy

Q: Is it sufficient to post on intranet, email, etc?

A: How to satisfy this requirement is left up to each entity for its own judgment.

Q: If the policies say that non-employee providers, contractors, vendors etc. must abide by and adhere to their policies, is it enough to just distribute without any additional training?

A: Yes. The law does not provide for training per se. The entity must simply educate the receiving parties.

$5M Threshold: How to Calculate and Other Information

Q: If parent company has individual subsidiary companies and none of them individually reaches the threshold, does the $5M threshold get transferred to parent as a combination of all of the subsidiaries?

A: If any one component of the system would reach the $5M threshold then each component will have to comply. If multiple components of the system receive an annual aggregate of $5M, then the parent health system would constitute an entity and must comply.

Q: If the individual pays a portion of his/her medical bills directly to the entity, is this included in the $5M threshold?

A: No, the entity must be paid by the Medicaid program. Patient paid amounts are not included. This issue will be benchmarked for specific follow up.

Q: Cash vs. Accrual / Date of service vs. Date of payment - If the entity doesn't actually receive the money in the fiscal year because the payment is delayed or denied does this count?

A: Each state will decide for itself whether it will apply date of service or date of payment and apply it consistently within the state.

Q: If the parent company has separate component entities, and none of the entities reaches the threshold individually, and the parent is not a provider in its own right, how is the $5M threshold calculated?

A: Not enough time to address this issue. CMS will specifically address this later.

Q: If the entity is nowhere near the $5M threshold but it contracts with an HMO that does meet the threshold, does the entity have to comply?

There is an inherent difficulty in having multiple contractor status (i.e. multiple entities are sending compliance plans). CMS has not figured out how to deal with this and will drill down into it more specifically.

Q: Definition of an Entity for threshold purposes.

A: State must decide but must be internally consistent.

Q: Do you count the amount billed or amount received when calculating the $5M threshold?

A: Amount of money actually received.
Q: If you have a Medicaid provider that is one single entity and has multiple provider numbers with different states, do you look at an aggregate of all states or in one state?

A: Only have to comply if you are $5M or more in a single state.

Q: Are there any exceptions to the $5M where a facility would still have to abide? (For example: a skilled nursing facility doing $4M in Medicaid payments per year)

A: No, they have not contemplated any exceptions. This facility would not be considered an entity.

Other Issues

Q: What does “specific or detailed” mean for the level of content in the policy?

A: No guidance was provided about how specific the policies must be. CMS has not provided model language and has not directed the states to do so either. Each entity will have to decide for itself.

Q: Employee education.

A: No formal education is required. CMS has not provided direction to the states about the methods of enforcing the education requirement.

Q: What is the date by which providers must notify contractors and agents?

A: January 1, 2007 - The requirements are binding on the individual entities regardless of whether the applicable state has provided a state plan.

Q: Is there going to be any phase in to enforcement because there are still fundamental basic issues that have not been addressed and there are Medicaid payments at risk?

A: CMS is planning to issue the guidance as soon as possible. CMS has no authority to grant any grace period, etc. Entities should still have interpreted the law and complied regardless of CMS guidance.

Miscellaneous

Q: What happens if an entity already has contracts with contractors and vendors in place, do the contracts have to be amended?

A: No guidance provided. CMS cannot give legal advice. The entity must do whatever is necessary to comply with the law. How the entity goes about complying with the law is up to the individual entity. CMS guidance does not mandate contract amendments.

Q: Are billing and coding vendors required to accept policy and procedures?

A: Yes. They are integral to the functions of a health care system and would need to be included. They are not required to accept but you can’t utilize them if they don’t.

Q: Do the policies of an MCO need to apply to its health care providers when they have thousands of providers to contact?

A: Yes. CMS will provide more information concerning what to do if contractors are entities required to comply with the DRA requirements in their own right.

Q: Does the policy require the creation of an employee handbook?

A: There is no requirement that an entity create an employee handbook, however; if there is a handbook then the DRA requirements must be included.

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Issuers of tax-exempt health care bonds need to be aware of changes required in disclosure procedures and content in the coming months. One such procedural initiative by the Securities and Exchange Commission (Commission) relates to the location of any required filed disclosures.

On December 8, 2006, the Commission published Release No. 34-54683 proposing an amendment to Rule 15c2-12 (Rule) under the Securities Exchange Act of 1934 (Act) relating to municipal securities disclosure. Currently, the Rule requires underwriters of certain municipal securities, prior to underwriting a primary offering of municipal securities of $1 million or more, to obligate issuers in a written agreement or contract for the benefit of bondholders to provide certain continuing disclosure information. Issuers are required to send certain material event notices designated by the Rule – such as principal and interest payment delinquencies and non-payments related defaults – to each nationally recognized municipal securities information repository (NRMSIR) or the Municipal Securities Rule Making Board (MSRB), and the appropriate state information depository (SID). The Rule also requires an issuer to notify the NRMSIRs or the MSRB, and the appropriate SID if it fails to provide annual financial information to such repositories by the agreed-upon date. Filing with the MSRB is optional, because the Rule can be satisfied by sending notice to each of the NRMSIRs rather than to the MSRB.

In response to a petition by the MSRB, the Commission proposes to amend the Rule by deleting the reference to the MSRB as an alternative filing site so that notices would be filed with each NRMSIR and any appropriate SID. The Commission believes that eliminating the MSRB filing option would help ensure that material event information is disseminated widely to the municipal securities marketplace. According to the Commission’s Web site, the proposal has received only one comment – a letter from the MuniCouncil that supports the proposed amendment to the Rule. The MuniCouncil is a group of 18 organizations representing all aspects of the municipal bond industry, including, for example, the Healthcare Financial Management Association, the National Association of Health Facilities Finance Authorities and the National Association of Bond Lawyers.

When the Rule was adopted in 1994, the Commission included the MSRB for dissemination of material event notices for two primary reasons: (1) the MSRB already had a voluntary disclosure system in place for receiving and disseminating certain material event notices; and (2) some commentators had expressed a preference to file notices in one central location rather than having to file with multiple NRMSIRs. The Commission no longer believes inclusion of the MSRB filing option is helpful for several reasons. Submissions to the MSRB have dropped considerably from over 10,000 to approximately 1,000 to 2,500 annually in the last several years. Although the MSRB believes that most of the material event notices it receives are also sent to, or otherwise obtained by, the NRMSIRs, the MSRB and the Commission are concerned that those notices that are sent only to the MSRB (and not the NRMSIRs) may not be reaching the broader market as intended by the Rule because only some of the NRMSIRs subscribe to the MSRB dissemination system. Also, alternative document delivery systems have become available to issuers and...
John W. Jones Jr. to Speak on Corporate Compliance for Pharmacies

Pepper partner John W. Jones Jr. is on the faculty of the Fourth Annual MHA Business Summit, a conference held by the nation’s largest alternate site GPO. The summit is slated for March 15-16, 2007, at The Venetian in Las Vegas, Nevada.

Mr. Jones will speak on “Corporate Compliance: Fraud and Abuse Issues Impacting Pharmacies.”

Last year’s Business Summit attracted over 250 pharmacy attendees and 150 industry partners. The focus of this year’s Business Summit will be long-term survival strategies under Medicare Part D. Additionally, new challenges such as electronic prescribing, AMP, pedigree requirements, returns, credits, repackaging, and other current issues will be discussed. This year’s Business Summit will feature speakers from many different sectors of the industry and presentations by progressive thought-leaders.

For more information or to register visit mhabizsummit.com.

No real disadvantage is apparent from the elimination of the MSRB from the Rule. Arguably, those few issuers that send material event notices only to the MSRB could experience a minimal increase in compliance costs if they decide to send the notices to all four NRMSIRs separately. However, with the advent of a free alternative document delivery system and dissemination agents that allow issuers to deliver the notices to a single location for delivery to all of the NRMSIRs and appropriate SIDs, this may not be an issue.

Considering the above analysis, the proposed amendment to the Rule likely will be adopted. The comment period for the proposed amendment ended on January 8. Look for the Commission’s final decision, which may impact upon health care institutions that have issued tax-exempt financing governed by the Rule, in the near future.

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