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Provider Proposal Using National Provider Identifiers (NPIs)

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# Introduction

Historically MHDO has generated its own unique provider identifier, known as the Provider IDN (e.g., MC912\_PRVIDN) and populated this on claims data rows in place of the detailed provider information sent in on the claims. This provider information from the claim is stored in provider detail tables such as MC\_Providers which are linked to the claims data by Provider IDN. Since each unique combination of provider information data fields is assigned a unique Provider IDN, the original state of the claim can be reconstructed using these two files.

However, a single individual or organization-level provider may be associated with many different Provider IDNs. Not only does each payer have their own unique provider identifiers that are included in the detail information, different claims within the same payer may have different information about the same provider.

In order to improve the utility of the data and allow MHDO and third party data users to identify unique individual or organization-level providers, the MHDO has historically associated each Provider IDN with a DPCID. Provider IDNs with the same DPCID have been identified as all belonging to the same entity. This has allowed for claims data to be analyzed and reported at the provider level.

# Issues with DPCID

There are two types of DPCIDs that may be assigned to Provider IDNs. The first kind is a “matched DPCID.” Each DPCID is associated with a single master file row that identifies a known entity. Once a Provider IDN is associated with a master file row, the claims associated with that Provider IDN are considered to be “matched,” meaning that they can be included in provider-level analyses. The second type of DPCID is an “unmatched DPCID.” These DPCIDs are not associated with a master file row. No unique entity has yet been determined for this Provider IDN. Claims associated with unmatched DPCID are considered to be “unmatched,” meaning that they cannot be included in any provider-level analyses. In some cases, provider records are unmatched because they literally contain no identifying information about the provider. In other cases, information is provided, but a match has not yet been made.

Matched DPCIDs are matched to entities in a variety of ways. The predominant, automated method involves a matching of unmatched Provider records to that provided on matched Provider records. So, if an unmatched Provider record has the same name and National Provider Identifier (NPI) it would be assigned the same DPCID as the matching record. Unmatched Provider records associated with a large number of claims go through a manual review process where an analyst performs research in an attempt to make a match. If the analyst determines that an unmatched Provider record represents a new entity, a new master file row will be added. Otherwise, the DPCID of an existing master file row will be used.

Since the automated matching relies on previously matched data, it is susceptible to bad data. Since the submitted provider information may be internally contradictory, this can cause erroneous names or NPIs to become associated with a given provider. This can lead to a future matching error.

Due to the conflicting nature of the submitted provider information, it can actually be impossible for a human analyst to determine who the actual provider is. For instance, past analysis has shown that the name and NPI for a servicing provider may represent different individuals in the same organization. In some cases, the first and last names are of different individuals. Thus, some of the current matched DPCIDs represent “best guesses” of the provider based on imperfect and sometimes incomplete information.

# Advantages of the NPI

The NPI is a single identifier that uniquely identifies an individual or an organization. The National Plan & Provider Enumeration System (NPPES) registry maintains name and address information, information about taxonomy codes and licensing. This registry is freely available from the NPPES. For more information, please see *Appendix A: What Is an NPI?*

Since 2004, MHDO has included the servicing provider NPI in the medical and dental claims format. Billing provider NPI for medical and dental claims was added in 2010. Prescribing physician NPI or DEA number has been included in the pharmacy claims format since 2006; these two items were segregated into their own distinct fields in 2014. While initially, the use of NPI by payers was limited. For instance, in 2005, only 0.04% of medical claims included either a servicing provider NPI. However, the usage of NPI in the insurance industry has grown dramatically. By 2010, 79.1% of medical claims had either a servicing or billing NPI on the claim. Looking at the last two years of claims data, 97% of medical claims have either a billing or a servicing NPI. Thus, the NPI provides fairly comprehensive coverage.

A recent analysis by the Maine Health Management Coalition as shown that the NPIs associated with a claim are a reliable indicator of the provider, even when it conflicts with other information provided, such as the provider name. There is more ambiguity as to how the other fields are supposed to be used, but the use of the NPI is well understood by payers.

# Replacement of DPCID with NPI

MHDO recently began releasing both billing and servicing NPI as a part of its practitioner identifiable data release. Given the costs and issues identified with the DPCID and the current high coverage and reliability of the NPI, we propose to phase out the use of DPCID in favor of the latter. While certain claims will lack the NPI going forward, the practitioner identifiable data release will still contain the other provider information from the claim, allowing end users to perform additional matching, if they require it. This will allow MHDO to focus its efforts on:

* Improving the coverage rate for NPI on claims,
* and developing data products that contain information on the nesting of individual providers within organizations and other such relationships.

We believe that using the NPI as the single canonical identifier of the servicing and billing providers will help encourage payers and data submitters to focus their own quality control efforts on those fields.

We propose to implement this replacement as follows.

# Phase 1 – Q4 2014 Release (week of 4/6/15)

## Create DPCID-NPI Crosswalk

As noted above, much of our historical data does not have an NPI associated with it. Therefore, the DPCID is the only entity identifier available. In order to allow data users to link providers across time, they will need a way to associate the old matched DPCIDs with NPIs.

As a part of the next release, we will therefore supply a crosswalk of the current DPCIDs to their associated NPIs. The current medical claims provider master file is over 60,000 records. While we anticipate that we will be able to determine NPIs for the majority of these records, there will inevitably be some for which no NPI was ever assigned. However, since these are likely not currently practicing providers, it is unlikely we will receive new data for these providers.

This crosswalk will leave users of our historical data with both the historical DPCID and an NPI for most records.

## Assignment of New DPCIDs

We will need to continue creating DPCIDs for use by data users who do not receive practitioner-identifiable data. They only receive a very small amount of information about the provider on a claim; this doesn’t include the name or the NPI. These data users will still need a way to group claims associated with a given provider.

Once the crosswalk indicated above is created, there will be a one-to-one correspondence between DPCID and NPI for those records we were able to identify (in situations where multiple DPCIDs mapped to the same NPI, one will be selected as the canonical relation). Any time new data comes in associated with such an NPI, the Provider record will be assigned the associated DPCID. If the NPI is not currently associated with a DPCID, a new DPCID-NPI relationship will be created. In the event that no NPI is provided on the claim, the DPCID used will be associated with UNKNOWN PROVIDER, regardless of the other information on the claim.

## Impact on Support Files

Currently, data releases include both a provider detail and a provider master file. As outlined above, the detail file contains the provider information as observed on the claim and the master file contains canonical information about the entity. We will continue to distribute these files. However, any DPCID that has been associated with an NPI will have the information in the master file replaced with the corresponding information from the NPPES registry. Only those DPCIDs for which no NPI was found will contain to have the current information. The master files will primarily be useful to data users who do not get practitioner-identifiable data.

## Determine Scope of Future Index/Directory

Given that the NPPES already maintains a registry of providers that we are linking to, we need to evaluate what, if anything, the MHDO should develop as a provider index or directory. We have already identified that there is likely value to the field in maintaining hierarchal data that represents how individual providers are nested within practice sites, organizations, and health plans.

To determine this revised scope, we intend to do the following:

* Get Payer Perspective: is there interest in this product, and are they willing to pay for it.
* Determine how to handle organizational data that changes frequently, so the index doesn’t become static.
* Talk with APCD Council and possibly other states to see what approach other states are taking
* Talk to the SDUG about potential quality reporting on provider information on claim, such as rate of mismatch between NPI and name, etc.

# Phase 2 – TBD

Based on the scope determinations outlined above, we anticipate that future tasks will include:

* Updating Chapter 630 to require NPI be supplied as a part of hospital organizational data.
* Obtaining and integrating provider lists from payers on a voluntary basis.
* Enhancing data release to include information on service site location, provider address, etc.
* Distributing value-added information about hierarchical relationships.
* Create hierarchical structure for supporting information about providers.

Appendix A

# What is the NPI?

*The following information has been pulled from the CMS NPI: What You Need to Know booklet:* [*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPIBooklet.pdf*](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPIBooklet.pdf)

A National Provider Identifier (NPI) is a unique identification number for covered health care providers, created to improve the efficiency and effectiveness of electronic transmission of health information. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the adoption of a standard, unique health identifier for each health care provider. The NPI Final Rule, published on January 23, 2004, established the NPI as this standard. Covered entities under HIPAA must use NPIs to identify health care providers in HIPAA standard transactions.

**Who may obtain an NPI?** All health care providers (that is, physicians, suppliers, hospitals, and others) may obtain an NPI. Health care providers are individuals or organizations that render health care as defined in 45 Code of Federal Regulations (CFR) 160.103.

**Who must obtain an NPI?** All health care providers who are HIPAA-covered entities, whether individuals or organizations, must obtain an NPI. Under HIPAA, you are a covered health care provider if you electronically transmit health information in connection with a HIPAA standard transaction, even if you use a business associate to do so.

**Who may not obtain an NPI?** Any entity that does not meet the definition of a health care provider as defined in 45 CFR 160.103 may not apply for an NPI. Such entities include billing services, value-added networks, repricers, health plans, health care clearinghouses, non-emergency transportation services, and others.

**What are the health care provider NPI categories?** There are two categories of health care providers for NPI enumeration purposes: Entity Type 1 (Individual) and Entity Type 2 (Organization).

*Entity Type 1: Individual Health Care Providers, including Sole Proprietors*

Individual health care providers may receive NPIs as Entity Type 1. As a sole proprietor, you must apply for the NPI using your own Social Security Number (SSN), not an Employer Identification Number (EIN) even if you have an EIN.

As a sole proprietor, you may receive only one NPI, just like any other individual. For example, if a physician is a sole proprietor, the physician may receive only one NPI (the individual’s NPI). The following factors do not affect whether a sole proprietor is an Entity Type 1:

* Number of different office locations;
* Whether you have employees;
* and Whether the Internal Revenue Service (IRS) issued an EIN to you so your employees’ W-2 forms can reflect the EIN instead of your Taxpayer Identification Number (which is your SSN).

NOTE: A sole proprietor is not an incorporated individual because the sole proprietor did not form a corporation. If you are a sole practitioner or solo practitioner,

*Entity Type 2: Organization Health Care Providers*

Organization health care providers are group health care providers and are eligible for NPIs as Entity Type 2. Organization health care providers may have a single employee or thousands of employees. For example, an incorporated individual may be the only health care provider employed by that organization provider (the corporation that he or she formed).

Some organization health care providers are made up of components that function somewhat independently from their “parent” organization. These components may furnish different types of health care or have separate physical locations where health care is furnished. These components and their physical locations are not themselves legal entities, but are part of the organization health care provider (which is a legal entity). The NPI Final Rule refers to the components and locations as subparts.

An organization health care provider can get its subparts their own NPIs. If a subpart conducts any HIPAA standard transactions on its own (that is, separately from its parent), it must obtain its own NPI.

Subpart determination ensures that entities within a covered organization are uniquely identified in HIPAA standard transactions they conduct with Medicare and other covered entities. For example, a hospital offers acute care, laboratory, pharmacy, and rehabilitation services. Each of these subparts may require its own NPI because each one sends its own standard transactions to one or more health plans.

NOTE: Subpart delegation does not affect Entity Type 1 health care providers. As individuals, these health care providers cannot designate subparts, and cannot be considered subparts.