The National Provider Identifier

NOTE: The information in this document is, to the best of our knowledge, accurate as of February 24, 1999. If you have questions on a specific aspect of the National Provider Identifier, you may direct your question to MEDICARESTATS.

On May 7, 1998, the Department of Health and Human Services (DHHS) published in the Federal Register the Notice of Proposed Rulemaking (NPRM) for the National Provider Identifier (NPI). The NPRM recommended the adoption of the NPI as the standard health care provider identifier. Public comments were accepted for 60 days after publication of the NPRM. This document reflects the NPI as proposed in the NPRM. DHHS is preparing the Final Rule, which will address the public comments and may, therefore, contain changes from the NPRM proposal. The Final Rule will announce the standard health care provider identifier.

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o Availability of the NPRM

The Notice of Proposed Rulemaking (NPRM) recommending the National Provider Identifier (NPI) as the

standard health care provider identifier was published in the Federal Register on May 7, 1998. The NPRM is available from several sources:

- The Department of Health and Human Services' (DHHS) administrative simplification website (http://aspe.os.dhhs.gov/admnsimp/) has posted the NPRM. Electronic comments can be submitted via that website. The PDF format makes the NPRM appear in the format used by the Federal Register.

- The Government Printing Office (GPO) website (www.access.gpo.gov/su_docs) is a link to the Federal Register. After going to that link, you would search on 1998 Federal Register. Link to Proposed Rules.

- A paper copy can be obtained by writing to New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. You may also place a credit card order by telephoning the order desk at (202) 512-1800, or by faxing to (202) 512-2250. Each copy costs $8.00.

- You can also view and copy the Federal Register at libraries designated as Federal Depository Libraries and at many public and academic libraries.

o **Need for a Standard Health Care Provider Identifier**

Currently, there is no universally accepted national identification and enumeration system for health care providers. Providers must use multiple identifiers for programs and organizations with which they do business. Data are not readily transportable among systems and, thus, must be collected redundantly. The problems and costs of exchanging provider data are great, hampering coordination of benefits and fraud and abuse detection efforts.

Organizations with a need to enumerate providers have joined in an effort, begun by the Health Care Financing Administration in 1993, to establish a national system for identifying and uniquely enumerating health care providers. The National Provider System has been designed to enumerate health care providers by assigning an identifier--the National Provider Identifier (NPI)--to each individual, organization, and group provider.

o **Participation in the National Provider Identifier Effort**

In July 1993, the Health Care Financing Administration (HCFA) undertook a project to develop a provider identification system to meet Medicare and Medicaid needs and ultimately a national identification system for all health care providers to meet the needs of other users and programs. HCFA convened a workgroup that included representatives from the private sector and Federal and State agencies who shared these same goals. Organizations that participated in this effort in addition to HCFA included:

- Department of Defense/OCHAMPUS
- Department of Health and Human Services/ASPE, PHS, FDA

- Department of Labor
- Department of Veterans Affairs
- Drug Enforcement Administration
- Office of Personnel Management
- Social Security Administration
- State Medicaid agencies and health departments, including those of Alabama, California, Pennsylvania, Minnesota, and Virginia
- Medicare contractors
- Professional and medical associations, including the American Medical Association, American Hospital Association, Health Insurance Association of America, and National Council of Prescription Drug Programs
- Regional consortia, including the Massachusetts Health Data Consortium, Utah Health Information Network, and Administrative Uniformity Committee of Minnesota
- Claims clearinghouses
- Standards groups, including the American National Standards Institute/Health Informatics Standards Planning Panel and the Accredited Standards Committee X12N Workgroup on Provider Information

o **Consideration of Existing Identifiers**

One of the workgroup's first tasks was to decide whether to use an existing identifier or to develop a new one. The group began by adopting criteria for a unique provider identifier recommended by the Workgroup for Electronic Data Interchange (WEDI), Technical Advisory Group in October 1993, and by the American National Standards Institute (ANSI), Health Informatics Standards Planning Panel, Task Group on Provider Identifiers in February 1994. The workgroup examined existing identifiers and concluded that no existing identifier met all the criteria that had been recommended by the WEDI and ANSI workgroups. They learned that some existing identifiers, such as the Employer Identification Number, the Social Security Number, and the Drug Enforcement Administration number, were established for other government programs and are not appropriate for identification of health care providers. Others, such as the National Supplier Clearinghouse number and the Unique Physician Identification Number, apply only to small segments of the health care provider community. And others, such as the Medicare provider number assigned to certified--primarily institutional--providers, have a format that will not accommodate a sufficient number of future health care providers. Some existing identifiers, such as the Health Industry Number, developed by the Health Industry Business Communications Council, are proprietary. Workgroup members expressed concerns with cost of access and protection of privacy in using a proprietary identifier. All existing identifiers lack an associated robust provider taxonomy that accommodates all types of health care providers.

Because of the limitations of existing identifiers, the workgroup advocated the development of a new identifier, called the National Provider Identifier (NPI), that would be in the public domain and that would incorporate the recommendations of the WEDI and ANSI workgroups. This new identifier, the National Provider Identifier (NPI), will use the extensive provider taxonomy being developed by the Accredited Standards Committee (ASC) X12N Workgroup on Provider Information. The ASC X12N provider taxonomy is available on the Internet at **www.wpc-edi.com/Index.html**.

As a result of this project, and before legislation required the use of the standard identifier for all health care providers, HCFA and other participants accepted the workgroup's recommendation, and HCFA decided that this new identifier would be implemented in the Medicare program. HCFA began to develop the National Provider System (NPS), which would capture the information necessary to uniquely identify a health care provider, store it in a database called the National Provider File (NPF), and assign an NPI to each uniquely identified health care provider.

o **Format of the National Provider Identifier**

In the NPRM, the National Provider Identifier (NPI) is proposed as an 8-position alphanumeric identifier. The NPI would contain no embedded intelligence; that is, information about the health care provider, such as the type of health care provider or State where the health care provider is located, would not be conveyed by the NPI. While this type of information would be recorded in the National Provider File, it would not be part of the identifier.

The eighth position of the NPI would be a numeric check digit which will assist in identifying erroneous or invalid NPIs. The check digit is a recognized International Standards Organization (ISO) standard. The check digit algorithm must be computed from an all-numeric base number. Therefore, any alpha characters that may be part of the NPI would be translated to specific numerics before the calculation of the check digit.

The NPI format would allow for the creation of approximately 20 billion unique identifiers.

The 8-position alphanumeric format was chosen over a longer numeric-only format in order to keep the identifier as short as possible while providing for an identifier pool that would serve the industry's needs for a long time. Some health care providers and health plans might have difficulty in the short term in accommodating alphabetic characters. In order to afford them additional time to accommodate alphabetic characters, the National Provider System has been designed to issue numeric-only identifiers first and to later introduce alphabetic characters starting with the first position of the NPI.

o **The Health Insurance Portability and Accountability Act (HIPAA) of 1996**

On August 21, 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes provisions to address the need for a standard health care provider identifier and other standards that would lead to administrative simplification. It mandates the establishment of these standards for use in the following electronic transactions: health claims, health encounter information, health claims attachments, health plan enrollments and disenrollments, health plan eligibility, health care payment and remittance advice, health plan premium payments, first report of injury, health claim status, and referral certification and authorization.

The Secretary of the Department of Health and Human Services (HHS) is charged with adopting the administrative simplification standards. The standards are applicable to health plans and health care clearinghouses that transmit any health information in electronic form in connection with the transactions listed above, and to health care providers that conduct electronically any of those transactions. HIPAA stipulates the way in which the standards are to have been, or are to be, established, the consultations required, and the dates by which the standards must be set and implemented. HIPAA also

gives HHS the authority to impose penalties on providers that conduct electronically any of the transactions listed above, health care clearinghouses, and health plans that delay, do not use, or misuse the standards. The process by which modifications and changes to standards may be made is also contained in this legislation.

o **Requirements for Developing and Adopting Administrative Simplification Standards**

In order to comply with HIPAA in establishing the standards, the Department of Health and Human Services (HHS) must rely on the recommendations of the National Committee on Vital and Health Statistics (NCVHS), consult with appropriate State, Federal, and private agencies or organizations, and publish the recommendations of NCVHS in the Federal Register.

HHS has organized interdepartmental implementation teams to identify and assess potential standards, including those for a health care provider identifier. A separate team addresses cross-cutting issues and coordinates the work of the implementation teams. The teams consult with NCVHS and standard setting organizations. The teams are charged with developing regulations and other necessary documents and making recommendations for the various standards to the HHS Data Council. (The Data Council is the focal point for consideration of data policy issues. It reports directly to the Secretary of HHS and advises her on data standards and privacy issues.)

HHS is developing recommendations for the standards to be adopted. The recommendations are being put in the form of Notices of Proposed Rulemaking (NPRMs) for publication the Federal Register. Each NPRM provides the public with a 60-day comment period. The public comments will be reviewed and analyzed, and Final Rules will then be published in the Federal Register; the Final Rules will announce the adoption of the standards.

o **Definitions of Health Care Providers: Individuals, Organizations, Groups**

The NPI NPRM defined a health care provider as an individual, group, or organization that provides medical or other health services or supplies. This definition 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.

The proposed definition of a health care provider would not include health industry workers who support the provision of health care but who do not provide health services, such as admissions and billing personnel, housekeeping staff, and orderlies.

In the NPRM, we proposed and requested comments on two alternatives for defining the general categories of health care providers for enumeration purposes. The first alternative categorized health care providers as individuals, groups, or organizations. The second alternative categorized health care providers as individuals or organizations (groups would be considered organizations).

Individuals would be treated differently than organizations and groups because the data available to search for duplicates (for example, date and place of birth) are different. Organizations and groups may need to be treated differently from each other because it is possible that a group is not specifically licensed or certified to provide health care, whereas an organization usually is. It may, therefore, be important to be

able to link the individual members to the group. It would not be possible to distinguish one category from another by looking at the NPI. The National Provider System (NPS) would contain the kinds of data necessary to uniquely identify each category of health care provider. Those categories are described as follows:

Individual--A human being who is licensed, certified or otherwise authorized to perform medical services or provide medical care, equipment or supplies in the normal course of business. Examples of individuals are physicians, nurses, dentists, pharmacists, and physical therapists.

Organization--An entity, other than an individual, that is licensed, certified or otherwise authorized to provide medical services, care, equipment or supplies in the normal course of business. The licensure, certification, or other recognition is granted to the organization entity. Individual owners, managers, or employees of the organization may also be certified, licensed, or otherwise recognized as individual health care providers in their own right. Each separate physical location of an organization, each member of an organization chain, and each subpart of an organization that needs to be identified would receive its own NPI. NPIs of organization providers (e.g., hospitals) would not be linked within the NPS to NPIs of other health care providers (e.g., physicians who work in the hospitals). Examples of organizations are hospitals, laboratories, ambulance companies, health maintenance organizations, and pharmacies.

Group--An entity composed of one or more individuals (as defined above), generally created to provide coverage of patients' needs in terms of office hours, professional backup and support, or range of services resulting in specific billing or payment arrangements. It is possible that the group itself is not licensed or certified, but the individual(s) who compose the group are licensed, certified or otherwise authorized to provide health care services. The NPIs of the group member(s) would be linked within the NPS to the NPI of the group. An individual can be a member of multiple groups. Examples of groups are (1) two physicians practicing as a group where they bill and receive payment for their services as a group and (2) an incorporated individual billing and receiving payment as a corporation.

The ownership of a group or organization can change if it is sold, consolidated, or merged, or if control changes due to stock acquisition. In many cases, the nature of the provider itself (for example, its location, staff or types of services provided) is not affected. In general, the NPI of the provider should not change in these situations.

o **Practice Addresses and Group/Organization Options**

We have had extensive consultations with health care providers, health plans, and members of health data standards organizations on the requirements for provider practice addresses and the group and organization structures in the National Provider System (NPS). Here are the major questions:

· Should the NPS capture practice addresses of health care providers?

For: Practice addresses could aid in non-electronic matching of health care providers and in conversion of existing provider number systems to NPIs. They could be useful for research specific to practice location; for example, involving fraud or epidemiology.

Against: Practice addresses would be of limited use in the electronic identification and matching of health care providers. The large number of practice locations of some group providers, the frequent relocation of provider offices, and the temporary situations under which a health care provider may practice at a particular location would make maintenance of practice addresses burdensome and expensive.

· Should the NPS assign a location code to each practice address in a health care provider's record? The location code would be a 2-position alphanumeric data element. It would be a data element in the NPS but would not be part of the NPI. It would point to a certain practice address in the health care provider's record and would be usable only in conjunction with that health care provider's NPI. It would not stand alone as a unique identifier for the address.

For: The location code could be used to designate a specific practice address for the health care provider, eliminating the need to perform an address match each time the address is retrieved. The location code might be usable, in conjunction with a health care provider's NPI, as a designation for service location in electronic health transactions.

Against: Location codes should not be created and assigned nationally unless required to support standard electronic health transactions; this requirement has not been demonstrated. The format of the location code would allow for a lifetime maximum of 900 location codes per health care provider; this number may not be adequate for groups with many locations. The location code would not uniquely identify an address; different health care providers practicing at the same address would have different location codes for that address, causing confusion for business offices that maintain data for large numbers of health care providers.

· Should the NPS link the NPI of a group provider to the NPIs of the individual providers who are members of the group?

For: Linkage of the group NPI to individual members' NPIs would provide a connection from the group provider, which is possibly not licensed or certified, to the individual members who are licensed, certified or otherwise authorized to provide health care services.

Against: The large number of members of some groups and the frequent moves of individuals among groups would make national maintenance of group membership burdensome and expensive. Organizations that need to know group membership prefer to maintain this information locally, so that they can ensure its accuracy for their purposes.

· Should the NPS collect the same data for organization and group providers? There would be no distinction between organization and group providers. Each health care provider would be categorized in the NPS either as an individual or as an organization. Each separate physical location or subpart of an organization that needed to be identified would receive its own NPI. The NPS would not link the NPI of an organization provider to the NPI of any other health care provider, although all organizations with the same employer identification number (EIN) or same name would be retrievable via a query on that EIN or name.

For: The categorization of health care providers as individuals or organizations would provide flexibility for enumeration of integrated provider organizations. Eliminating the separate category of group providers would eliminate an artificial distinction between groups and organizations. It would eliminate the possibility that the same entity would be enumerated as both a group and an organization. It would eliminate any need for location codes for groups. It would allow enumeration at the lowest level that needs to be identified, offering flexibility for enumerators, health plans or other users of NPS data to link organization NPIs as they require in their own systems.

Against: A single business entity could have multiple NPIs, corresponding to its physical locations or subparts.

Below are two alternatives which illustrate how answers to the questions posed above would affect enumeration and health care provider data in the NPS. The results would depend upon whether the health care provider is an individual, organization, or group.

Alternative 1:
The NPS would capture practice addresses. It would assign a location code for each practice address of an individual or group provider. Organization and group providers would be distinguished and would have different associated data in the NPS. Organization providers could have only one location per NPI and could not have individuals listed as members. Group providers could have multiple locations with location codes per NPI and would have individuals listed as members.

For individual providers, the NPS would capture each practice address and assign a corresponding location code. The NPS would link the NPIs of individuals who are listed as members of a group with the NPI of their group.

For organization providers, the NPS would capture the single active practice address. It would not assign a corresponding location code.

For group providers, the NPS would capture each practice address and assign a corresponding location code. The NPS would link the NPI of a group with the NPIs of all individuals who are listed as members of the group. A group location would have a different location code in the members' individual records and the group record.

Alternative 2:
The NPS would capture only one practice address for an individual or organization provider. It would not assign location codes. The NPS would not link the NPI of a group provider to the NPIs of individuals who are members of the group. Organization and group providers would not be distinguished from each other in the NPS. Each health care provider would be categorized as either an individual or an organization.

For individual providers, the NPS would capture a single practice address. It would not assign a corresponding location code.

For organization providers, each separate physical location or subpart that needed to be identified would receive its own NPI. The NPS would capture the single active practice address of the organization. It would not assign a corresponding location code.

Recent consultations with health care providers, health plans, and members of health data standards organizations have indicated a growing consensus for alternative 2 discussed above. Representatives of these organizations feel that alternative 2 will provide the data needed to identify the health care provider at the national level, while reducing burdensome data maintenance associated with provider practice location addresses and group membership. The Notice of Proposed Rulemaking will solicit comments on these and other alternatives for collection of practice location addresses and assignment of location codes, and on the group and organization provider data within the NPS.

o **Integrity of Data**
Data integrity will be controlled on three levels: error prevention, ongoing monitoring, and active auditing. Error prevention will be assured by building into the National Provider System adequate data edits and logic checks, as well as by setting pre-editing standards for organizations that provide the data. Ongoing monitoring will track the consistency and validity of the data and resolve discrepancies resulting from the receipt of data from multiple sources. Periodic auditing will be established to ensure that the data re not just reasonable or logically possible but are, in fact, correct.

o **National Provider File Data**

The NPRM proposed that the National Provider System (NPS) collect and store in the National Provider

File (NPF) a variety of information, the majority of which would be required to identify a provider uniquely. Other information would be used for administrative purposes, and a few of the data elements would be collected at the request of potential users who have been working with HCFA in designing the database prior to the passage of HIPAA. All of these data elements represent only a fraction of the information that would comprise a health care provider enrollment file. The data elements in the table entitled "National Provider File Data Elements" (below), plus cease/effective/termination dates, switches (yes/no), indicators, and history, are being considered as those that would form the NPF. We have included comments, as appropriate. The table does not display systems maintenance or similar fields, or provider cease/effective/termination dates.

National Provider File Data Elements

KEY: I - Used for the identification of a provider.
A - Used for administrative purposes.
U - Included at the request of potential users (optional).

Data Elements	Comments	Purpose
National Provider Identifier (NPI)	8-position alpha-numeric NPI assigned by the NPS.	I
Provider's current name	For Individuals only. Includes first, middle, and last names.	I
Provider's other name	For Individuals only. Includes first, middle, and last names. Other names might include maiden and professional names.	I
Provider's legal business name	For Groups and Organizations only.	I
Provider's name suffix	For Individuals only. Includes Jr., Sr., II, III, IV, and V.	I
Provider's credential designation	For Individuals only. Examples are MD, DDS, CSW, CNA, AA, NP, RNA, PSY.	I
Provider's Social Security Number (SSN)	For Individuals only.	I
Provider's Employer Identification Number (EIN)	Employer Identification Number.	I
Provider's birth date	For Individuals only.	I
Provider's birth State code	For Individuals only.	I
Provider's birth county name	For Individuals only.	I

Provider's birth country name	For Individuals only.	I
Provider's sex	For Individuals only.	I
Provider's race	For Individuals only.	U
Provider's date of death	For Individuals only.	I
Provider's mailing address	Includes 2 lines of street address, plus city, State, county, country, 5- or 9-position ZIP code.	A
Provider's mailing address telephone number		A
Provider's mailing address fax number		A
Provider's mailing address e-mail address		A
Resident/Intern code	For certain Individuals only.	U
Provider enumerate date	Date provider was enumerated (assigned an NPI). Assigned by the NPS.	A
Provider update date	Last date provider data was updated. Assigned by the NPS.	A
Establishing enumerator/agent number	Identification number of the establishing enumerator.	A
Provider practice location identifier (location code)	2-position alpha-numeric code (location code) assigned by the NPS.	I
Provider practice location name	Title (e.g., "doing business as" name) of practice location.	I
Provider practice location address	Includes 2 lines of street address, plus city, State, county, country, 5- or 9-position ZIP code.	I
Provider's practice location telephone number		A
Provider's practice location fax number		A
Provider's practice location e-mail address		A
Provider classification	From Accredited Standards Committee X12N taxonomy. Includes type(s), classification(s), area(s)	I

	of specialization.	
Provider certification code	For certain Individuals only.	U
Provider certification (certificate) number	For certain Individuals only.	U
Provider license number	For certain Individuals only.	I
Provider license State	For certain Individuals only.	I
School code	For certain Individuals only.	I
School name	For certain Individuals only.	I
School city, State, country	For certain Individuals only.	U
School graduation year	For certain Individuals only.	I
Other provider number type	Type of provider identification number also/formerly used by provider: UPIN, NSC, OSCAR, DEA, Medicaid State, PIN, Payer ID.	I
Other provider number	Other provider identification number also/formerly used by provider.	I
Group member name	For Groups only. Name of Individual member of group. Includes first, middle, and last names.	I
Group member name suffix	For Groups only. This is the Individual member's name suffix. Includes Jr., Sr., II, III, IV, and V.	I
Organization type control code	For certain Organizations only. Includes Government - Federal (Military), Government - Federal (Veterans), Government - Federal (Other), Government - State/County, Government - Local, Government - Combined Control, Non-Government - Non-profit, Non-Government - For Profit, and Non-Government - Not for Profit.	U

We need to consider the benefits of retaining all of the data elements shown in the table versus lowering the cost of maintaining the database by keeping only the minimum number of data elements needed for unique provider identification. The NPRM may solicit comments on the composition of the minimum set of data elements needed to uniquely identify each type of provider. In order to consider the inclusion or exclusion of data elements, we need to assess their purpose and use.

The data elements with a purpose of "I" are being proposed to identify a health care provider, either in the search process (which is electronic) or in the investigation of health care providers designated as possible matches by the search process. These data elements are critical because unique identification is the keystone of the NPS.

The data elements with a purpose of "A" are not essential to the identification processes mentioned above, but nonetheless are valuable. Certain "A" data elements can be used to contact a health care provider for clarification of information or resolution of issues encountered in the enumeration process and for sending written communications; other "A" data elements (e.g., Provider Enumerate Date, Provider Update Date, Establishing Enumerator/Agent Number) are used to organize and manage the data.

Data elements with a purpose of "U" are collected at the request of potential users of the information in the system. While not used by the system's search process to uniquely identify a health care provider, Race is nevertheless valuable in the investigation of health care providers designated as possible matches as a result of that process. In addition, Race is important to the utility of the NPS as a statistical sampling frame. Race is collected "as reported"; that is, it is not validated. The cost of keeping this data element is virtually nil. Other data elements (Resident/Intern Code, Provider Certification Code and Number, and Organization Type Control Code) with a purpose of "U", while not used for enumeration of a health care provider, have been requested to be included by some members of the health care industry for reports and statistics. These data elements are optional and do not require validation. Many data elements remain constant by their nature and the cost to store them is negligible.

The data elements that we judge will be expensive to either validate or maintain (or both) are the license information, provider practice location addresses, and membership in groups. The NPRM solicited comments on whether these data elements are necessary for the unique enumeration of providers and whether validation or maintenance is required for that purpose.

Licenses may be critical in determining uniqueness of a health care provider (particularly in resolving identities involving compound surnames) and are, therefore, considered to be essential by some. License information is expensive to validate initially, but not expensive to maintain because it does not change frequently.
The practice location addresses can be used to aid in investigating possible provider matches, in converting existing provider numbers to NPIs, and in research involving fraud or epidemiology. Location codes could be assigned by the NPS to point to and identify practice locations of individuals and groups. Some potential users felt that practice addresses changed too frequently to be maintained efficiently at the national level. The average Medicare physician has two to three addresses at which he/she practices. Group providers may have many more practice locations. We estimate that 5 percent of health care providers require updates annually, and that addresses are one of the most frequently changing attributes. As a result, maintaining more than one practice address for a health care provider on a national scale could be burdensome and time consuming. Many potential users believe that practice addresses, if required by a health plan, could more adequately be maintained at local, health-plan specific levels. The NPRM solicited comments on these issues.

Some potential users felt that membership in groups was useful in identifying health care providers. Many others, however, felt that these data are highly volatile and costly to maintain. These users felt it was unlikely that membership in groups could be satisfactorily maintained at the national level. The NPRM solicited comments on capturing and maintaining membership in groups.

o **Dissemination of Data**

Certain information about individual providers must and will be protected in accordance with the Privacy

Act. Enumerators, with on-line access to the National Provider File, will be required to adhere to the provisions of the Privacy Act. The National Provider System will maintain sophisticated technical and physical safeguards for the data.

The NPRM stated that separate Public Use Files would be available to the public, and a query and report facility separate from the National Provider System would be developed for public use.

Information would be made available from the NPS so that the administrative simplification provisions of HIPAA can be implemented smoothly and efficiently. In addition to a health care provider's name and NPI, it is important to make available other information about the health care provider so that people with existing health care provider files can associate their health care providers with the appropriate NPIs. The data elements we would propose to disseminate are the ones that our research has shown would be the most beneficial in this matching process. The information needs to be disseminated to the widest possible audience because the NPIs would be used in a vast number of applications throughout the health care industry.

We propose to charge fees for the dissemination of such items as data files and directories, but the fees would not exceed the cost of the dissemination.

For purposes of disseminating information from the National Provider File (NPF), we recommended in the NPRM the establishment of two levels of users. This is necessary because some of the information being collected in order to enumerate providers is confidential in nature and, as such, can only be released under the conditions of the Privacy Act.

Level I - Enumerators

Access to the National Provider System (NPS) would be limited to the approved enumerators. "Routine uses" for the data about individuals was published in the Federal Register in a Privacy Act System of Records Notice (HHS/HCFA/OIS No. 09-70-0008) on July 28, 1998.

Enumerators would have access to all data elements for all health care providers in order to accurately resolve potential duplicate situations (that is, the health care provider may already have been enumerated). Enumerators would be required to protect the privacy of the data in accordance with the Privacy Act.

Enumerators would have access to the on-line NPS and would also receive periodic batch update files from HCFA.

Level II - The Public

Selected data elements would be available to the public (which includes individuals, health care providers, software vendors, health plans that are not enumerators, and clearinghouses).

The table below lists the data comprising the NPF and indicates the proposed dissemination level (Level I or Level II).

Dissemination of Information from the National Provider File

Data Elements	Dissemination Level	Comments
National Provider Identifier (NPI)	I and II	8-position alpha-numeric NPI assigned by the NPS.
Provider's current name	I and II	For Individuals only. Includes first, middle, and last names.
Provider's other name	I and II	For Individuals only. Includes first, middle, and last names. Types of other names include maiden and professional.
Provider's legal business name	I and II	For Groups and Organizations only.
Provider's name suffix	I and II	For Individuals only. Includes Jr., Sr., II, III, IV, and V.
Provider's credential designation	I and II	For Individuals only. Examples are MD, DDS, CSW, CNA, AA, NP, RNA, PSY.
Provider's Social Security Number (SSN)	I only	For Individuals only.
Provider's Employer Identification Number (EIN)	I only	Employer Identification Number.
Provider's birth date	I only	For Individuals only.
Provider's birth State code	I only	For Individuals only.
Provider's birth county name	I only	For Individuals only.
Provider's birth country name	I only	For Individuals only.
Provider's sex	I only	For Individuals only.
Provider's race	I only	For Individuals only.
Provider's date of death	I only	For Individuals only.
Provider's mailing address	I and II	Includes 2 lines of street address, plus city, State, county, country, 5- or 9-position ZIP code.
Provider's mailing address telephone	I only	

number		
Provider's mailing address fax number	I only	
Provider's mailing address e-mail address	I only	
Resident/Intern code	I and II	For certain Individuals only.
Provider enumerate date	I and II	Date provider was enumerated (assigned an NPI). Assigned by the NPS.
Provider update date	I and II	Last date provider data was updated. Assigned by the NPS.
Establishing enumerator/agent number	I only	Identification number of the establishing enumerator.
Provider practice location identifier (location code)	I and II	2-position alpha-numeric code (location code) assigned by the NPS.
Provider practice location name	I and II	Title (e.g., "doing business as" name) of practice location.
Provider practice location address	I and II	Includes 2 lines of street address, plus city, State, county, country, 5- or 9-position ZIP code.
Provider's practice location telephone number	I only	
Provider's practice location fax number	I only	
Provider's practice location e-mail address	I only	
Provider classification	I and II	From Accredited Standards Committee X12N taxonomy. Includes type(s), classification(s), area(s) of specialization.
Provider certification code	I only	For certain Individuals only.
Provider certification (certificate) number	I only	For certain Individuals only.
Provider license number	I only	For certain Individuals only.
Provider license State	I only	For certain Individuals only.

School code	I only	For certain Individuals only.
School name	I only	For certain Individuals only.
School city, State, country	I only	For certain Individuals only.
School graduation year	I only	For certain Individuals only.
Other provider number type	I and II	Type of provider identification number also/formerly used by provider: UPIN, NSC, OSCAR, DEA, Medicaid State, PIN, Payer ID.
Other provider number	I and II	Other provider identification number also/formerly used by provider.
Group member name	I and II	For Groups only. Name of Individual member of group. Includes first, middle, and last names.
Group member name suffix	I and II	For Groups only. This is the Individual member's name suffix. Includes Jr., Sr., II, III, IV, and V.
Organization type control code	I and II	For certain Organizations only. Includes Government - Federal (Military), Government - Federal (Veterans), Government - Federal (Other), Government - State/County, Government - Local, Government - Combined Control, Non-Government - Non-profit, Non-Government - For Profit, and Non-Government - Not for Profit.

Clearly, the access method to the public data would have to be electronic in order to support the more frequent users. The Notice of Proposed Rulemaking solicited comments on the kind of information that shuld be available in hardcopy, the types of electronic formats that would be needed (for example, diskette, CD ROM, tape, cartridge, and via Internet), and the frequency of update. These data would be made as widely available as feasible.

o **<u>On-line Enumeration</u> of Health Care Providers**

The National Provider System (NPS) will contain on-line enumeration screens with standardized data elements and definitions. To speed up processing and enhance data integrity, both initial enumerations and data updates will be performed as interactive, on-line processes. Standard queries and reports will be available to enumerators, along with daily extracts that will show all health care provider records which have been added or updated since the last extract. The NPS will provide enumerators with tutorial training software, user manuals, and access to a Help Desk to encourage timely and accurate submission of enumeration data.

o **<u>Mandatory Data Elements</u> for On-line Enumeration**

Some data elements must be available and entered during the on-line enumeration in order to assign an NPI to a provider. Below is the list of these mandatory data elements.

For individuals:

FIRST NAME
LAST NAME
ADDRESS
CITY
COUNTRY - required if foreign address
FOREIGN POSTAL CODE - required if foreign address
STATE - required if not foreign address
ZIP CODE - required if not foreign address
PHONE
DATE OF BIRTH
STATE OF BIRTH - required if not foreign address
COUNTRY OF BIRTH - required if foreign address

Individual providers must have at least one active Classification. License information is required for some classifications.

For groups:

LEGAL BUSINESS NAME
EMPLOYER IDENTIFICATION NUMBER
ADDRESS
CITY
COUNTRY - required if foreign address
FOREIGN POSTAL CODE - required if foreign address
STATE - required if not foreign address
ZIP CODE - required if not foreign address
PHONE

Each Group must have at least one Group Member:

MEMBER NPI
FIRST 2 CHARACTERS OF LAST NAME

Each Group must have at least one Practice Location:
ADDRESS
CITY
COUNTRY - required if foreign address
FOREIGN POSTAL CODE - required if foreign address
STATE - required if not foreign address

ZIP CODE - required if not foreign address
PHONE

For organizations:

LEGAL BUSINESS NAME
EMPLOYER IDENTIFICATION NUMBER
ADDRESS
CITY
COUNTRY - required if foreign address
FOREIGN POSTAL CODE - required if foreign address
STATE - required if not foreign address
ZIP CODE - required if not foreign address
PHONE
Each Organization must have at least one Organization Classification.

Each Organization may have only one active Practice Location:

ADDRESS
CITY
COUNTRY - required if foreign address
FOREIGN POSTAL CODE - required if foreign address
STATE - required if not foreign address
ZIP CODE - required if not foreign address
PHONE

o **Enumerators**

The NPRM proposed that NPIs would be issued by one or more organizations known as "enumerators." Enumerators would carry out a number of functions, including entering identifying information about a health care provider into the system, performing data validation (for example, confirming the State license number), notifying a health care provider of its NPI, and updating information about a health care provider when notified by the health care provider. (Some of these functions could be redundant and thus unnecessary if the enumerator were also an entity that enrolls health care providers in its own health plan and would be enumerating health care providers in conjunction with enrolling them in its own health plan.) The National Provider System (NPS) would edit the data, checking for consistency, formatting addresses, and validating the Social Security Number. It would then search the database to determine whether the health care provider already has an NPI. If so, that NPI would be displayed. If not, an NPI would be assigned. If the health care provider is similar (but not identical) to an already-enumerated health care provider, the information would be passed back to the enumerator as a possible match for further analysis. The number of enumerators would be limited in the interest of data quality and consistency.

Each health care provider would be required to forward updates of its own data in the database to an NPI enumerator within 60 days of the date the change occurs. The NPRM solicited comments on whether such updates should be limited to only those data elements that are required to enumerate a health care provider (e.g., name, address).

The process of identifying and uniquely enumerating health care providers is separate from--but may be similar to--the process health plans follow in enrolling providers in their health programs. Even when the NPS begins assigning NPIs to health care providers, health plans would still have to follow their own procedures for receiving and verifying information from providers that apply to them for enrollment in their health programs.

Because the Medicare program maintains files on more health care providers than any other health care plan in the country, we envision using data from those files to initially populate the NPF that would be built by the NPS and accessed by the enumerator(s).

The major issue related to the operation of the enumeration process is determining who the enumerator(s) will be. Several choices are listed below, along with their advantages and disadvantages. This information was presented in the NPRM.

- **A registry:**

A central registry operated under Federal direction would enumerate all health care providers. The Federally-directed registry could be a single physical entity or could be a number of agents controlled by a single entity and operating under common procedures and oversight.

For: The process would be consistent; centralized operation would assure consistent data quality; the concept of a registry is easy to understand (single source for identifiers).

Against: The cost of creating a new entity rather than enumerating as part of existing functions (for example, plan enrollment) would be greater than having existing entities enumerate; there would be redundant data required for enumeration and enrollment in a health plan.

- **Private organization(s):**

A private organization(s) that meets certain selection criteria and performance standards, which would post a surety bond related to the number of health care providers enumerated, could enumerate health care providers.

For: The organization(s) would operate in a consistent manner under uniform requirements and standards; failure to maintain prescribed requirements and standards could result in penalties which could include suspension or debarment from being an enumerator.

Against: A large number of private enumerators would compromise the quality of work and be more difficult to manage; the administrative work required to set up arrangements for a private enumerator(s) may be significant; the cost of creating a new entity rather than enumerating as part of existing functions (for example, plan enrollment) would be greater than having existing entities enumerate; there ~~would~~ may be redundant data required for enumeration and enrollment in a health plan; the legality of privatization would need to be researched.

(Note: If private organizations as enumerators could charge health care providers a fee for obtaining NPIs, this enumeration option would be attractive and more preferable than the other choices or combinations, as it would offer a way to fund the enumeration function. In researching the legality of this approach, however, we were advised that we do not have the authority under the current law to (1) charge health care providers a fee for obtaining NPIs, or (2) license private organizations that would charge health care providers for NPIs. For these reasons, we will not present as a viable option in the Notice of Proposed Rulemaking (NPRM) the use of private organizations as enumerators.)

- **Federal health plans and Medicaid State agencies:**

Federal programs named as health plans and Medicaid State agencies would enumerate all health care providers. (As stated earlier under the definition of "health plan", the Federal Employees Health Benefits Program is comprised of numerous health plans, rather than just one, and does not deal directly with health care providers that are not also health plans. Thus, the program would not enumerate health care providers but would still require the NPI to be used.)

For: These health plans already assign numbers to their health care providers; a large percentage of health care providers do business with Federal health plans and Medicaid State agencies; there would be no appreciable costs for these health plans to enumerate as part of their enrollment process; a small number of enumerators would assure consistent data quality.

Against: Not all health care providers do business with any of these health plans; there would be the question of which health plan would enumerate the health care provider that participates in more than one; we estimate that approximately 5 percent of the State Medicaid agencies may decline to take on this additional task.

· **Designated State agency:**

The Governor of each State would designate an agency to be responsible for enumerating health care providers within the State. The agency might be the State Medicaid agency, State licensing board, health department, or some other organization. Each State would have the flexibility to develop its most workable approach.

For: This choice would cover all health care providers; there would be a single source of enumeration in each State; States could devise the least expensive mechanisms (for example, assign NPI during licensing); license renewal cycles would assure periodic checks on data accuracy.

Against: This choice would place an unfunded workload on States; States may decline to designate an agency; there may be insufficient funding to support the costs the States would incur; State licensing agencies may not collect enough information during licensing to ensure uniqueness across States; States may not be uniform in their definitions of "providers."

· **Professional organizations or training programs:**

We would enlist professional organizations to enumerate their members and/or enable professional schools to enumerate their students.

For: Individuals could be enumerated at the beginning of their careers; most health care providers either attend a professional school or belong to an organization.

Against: Not all health care providers are affiliated with an organization or school; this choice would result in many enumerators and thus potentially lower the data quality; schools would not be in a position to update data once the health care provider has graduated; the choice would place an unfunded workload on schools and/or organizations.

· **Health plans:**

Health plans in general would have access to the NPS to enumerate any of their health care providers.

For: Most health care providers do business with one or more health plans; there would be a relatively low cost for health plans to enumerate as part of enrollment; this choice would eliminate the need for redundant data.

Against: Not all health care providers are affiliated with a health plan; this choice would be confusing for the health care provider in determining which health plan would enumerate when the health care provider is enrolled in multiple health plans; there would be a very large number of enumerators and thus potentially serious data quality problems; the choice would place unfunded workload on health plans.

· **Combinations:**

We also considered using combinations of these choices to maximize advantages and minimize disadvantages.

The two most viable options are described below. We solicited input on these options, as well as on alternate solutions, in the NPRM.

Option 1: Registry enumeration of all health care providers.

All health care providers would apply directly to a Federally-directed registry for an identifier. The registry would be operated by an agent or contractor. This option is favored by some health plans, which believe that a single entity should be given the task of enumerating health care providers and maintaining the database for the sake of consistency. It would also be the simplest option for providers, since enumeration activities would be carried out for all providers by a single entity. The major drawback to this option is the high cost of establishing a registry large enough to process enumeration and update requests for the 1.2 million current and 30,000 new (annually) providers who conduct HIPAA transactions. The statute did not provide a funding mechanism for the enumeration/update function. Federal funds, if available, could support the registry.

This option does not offer a clear possibility for funding some of the costs associated with the operation and maintenance of the National Provider System (NPS) once it becomes national in scope (that is, enumerates health care providers that are not Medicare health care providers). The NPRM solicited comments on appropriate methods for funding the NPS.

Option 2: A combination of Federal programs (health plans), Medicaid State agencies, and a registry.

Federal programs and Medicaid State agencies would enumerate their own health care providers. Each health care provider participating in more than one health plan could choose the health plan by which it wishes to be enumerated. All other health care providers would be enumerated by a Federally-directed registry. These latter health care providers would apply directly to the registry for an identifier.

The number of enumerators, and the number of health care providers per enumerator, would be small enough to ensure careful validation of data. Moreover, enumerators (aside from the registry) would be dealing with their own health care providers, an advantage both in terms of cost equity and data quality. This option recognizes the fact that Federal programs and Medicaid State agencies already assign identifiers to their health care providers for their own programmatic purposes. It would standardize those existing processes and, in some cases, may increase the amount of data collected or validation performed.

We have concluded that the cost of concurrently enumerating and enrolling a Medicare provider is essentially the same as the cost of enrollment alone because of the high degree of redundancy between the processes. While there would probably be additional costs initially, they would be offset by savings in other areas (e.g., simplified, more efficient coordination of benefits; single enumeration of a health care provider; maintenance of only one identification number for a health care provider; maintenance of only one health care provider enumeration system).

The Federal Government is responsible for 75 percent of Medicaid State agency costs to enumerate and update health care providers. Because we believe the costs that would be incurred by Medicaid State agencies in enumerating and updating their own health care providers would be relatively low and offset by savings, we see no tangible costs involved.

Allowing these health plans to continue to enumerate their health care providers would reduce the registry workload and its operating costs. We estimate that approximately 85 percent of billing health care providers transact business with a Medicaid State agency or a Federal health plan. We estimate that 5 percent of Medicaid State agencies may decline to enumerate their health care providers. If so, that work would have to be absorbed by the registry. This expense could be offset by the discontinuance of the Unique Physician Identification Number (UPIN) registry, which is currently maintained with Federal funds. (The UPIN registry assigns, for the use of the Medicare program, an identification number to physicians and certain other health care providers.)

We solicited comments in the NPRM on the number of health care providers that would deal directly with a registry under this option and on alternative ways to enumerate them.

As with option 1, this option does not offer a clear possibility for funding some of the costs associated with the operation and maintenance of the NPS as it becomes national in scope. Again, in the NPRM, we solicited comments on appropriate methods for funding the NPS.

The NPRM stated that option 2 is more advantageous and less costly than option 1. Option 1 is the simplest for health care providers to understand but has a significant Federal budgetary impact. Option 2 takes advantage of existing expertise and processes to enumerate the majority of health care providers. This reduces the cost of the registry in option 2 to a point where it would be largely offset by savings from eliminating redundant enumeration processes.

o **Enumeration Phases**

Enumeration should occur in phases because the number of potential health care providers to be enumerated is too large to enumerate at one time, regardless of the number of enumerators. Below are the phases we recommended in the Notice of Proposed Rulemaking, described in the context of enumeration option 2 (enumerators would be a combination of Federal programs known as health plans, Medicaid State agencies, and a registry):

Health care providers that participate in Medicare would be enumerated first because, as the managing entity, HCFA has data readily available for all Medicare providers. Health care providers that are already enrolled in Medicare at the time of implementation would be enumerated based on existing Medicare provider databases that have already been reviewed and validated. These health care providers would not have to request an NPI--they would automatically receive one. After this initial enumeration, new health care providers not yet enumerated that wish to participate in Medicare would receive an NPI as a part of the enrollment process.

Secondly, Medicaid and non-Medicare Federal health programs that need to enumerate their health care providers would follow a similar process, based on a mutually agreed-upon timetable. These health plans' existing pre-validated provider enrollment databases could be used to avoid requiring large numbers of health care providers to apply for NPIs. If a health care provider were already enumerated by Medicare,

that NPI would be communicated to the second program. After the initial enumeration, new health care providers that wish to participate in Medicaid or a Federal program other than Medicare would receive an NPI as a part of that enrollment process. Health care providers that transact business with more than one such health program would be enumerated by the health program to which they apply first. This phase would be completed within 2 years after the effective date of the final rule.

Concurrent with the second enumeration phase (described above), health care providers that do not transact any business with Federal health plans or Medicaid, but that do conduct electronically any of the transactions stipulated in HIPAA, would be enumerated by the Federally-directed registry.

After the first two phases of enumeration are completed, the remaining health care providers would be enumerated by the Federally-directed registry. This would be the third phase of enumeration. The health care providers to be enumerated in this phase are those that do not conduct electronically any of the transactions stipulated in HIPAA. In some cases, these health care providers may need to be enumerated because health plans may prefer to use the NPI for all health care providers, whether or not they submit HIPAA transactions electronically, for the sake of processing efficiency. In addition, some health care providers may wish to be enumerated even though they conduct no designated transactions and are not affiliated with any health plan. These health care providers would not be enumerated until all the health care providers requiring NPIs (i.e., those that conduct electronically any of the transactions specified by HIPAA) are enumerated.

The Workgroup for Electronic Data Interchange has made recommendations concerning the 2-year implementation phase (3-year phase for small plans) for the NPI: (1) To allow health care providers, health plans, and health care clearinghouses the time needed to plan, test, and implement the NPI, the NPI should not be required to be used during the first year following its adoption; that is, those entities will have the first year following adoption to adequately ready themselves for mandatory usage, which will occur during the second year following adoption, but no later than the end of the second year (or third year for small plans). This proposal would not preclude willing trading partners from implementing the NPI at any time during the 2 years following its adoption (3 years for small plans). (2) In addition, health plans would give health care providers at least 6 months' advance notice of when usage of the NPI will be required. Plans would notify health care providers through their normal communications procedures.

o **Endorsement of the National Provider Identifier**

The NPI has been endorsed by the following government and private organizations:

> The State of Minnesota endorsed the use of the NPI in Minnesota Statutes section 62J.54, dated February 1996.
>
> The Massachusetts Health Data Consortium's Affiliated Health Information Networks of New England endorsed the NPI as the standard provider locator for electronic data interchange in March 1996.
>
> The USA Registration Committee approved the NPI as an International Standards Organization card issuer identifier in August 1996 for use on magnetic cards.
>
> The National Uniform Billing Committee endorsed the NPI in August 1996.

The National Council of Prescription Drug Programs endorsed the NPI in October 1996.
The American Dental Association expressed its support for the NPI in December 1996.

The Workgroup for Electronic Data Interchange supported the concept of the NPI as satisfying the national provider identifier requirement of HIPAA in May 1997.

The National Committee on Vital and Health Statistics endorsed the NPI in a Notice that was published in the Federal Register in July 1997.

o **Schedule for the National Provider Identifier**

The Health Insurance Portability and Accountability Act, enacted in August 1996, requires that the Department of Health and Human Services (HHS) adopt standards for specified transactions and data elements (one of which is the health care provider identifier). Compliance with the standards is required no later than 24 months after the adoption of the standard (36 months for small health plans).

HHS has prepared and published in the Federal Register a Notice of Proposed Rulemaking (NPRM) that recommended the adoption of the National Provider Identifier (NPI) as the standard health care provider identifier. The NPRM was published in the Federal Register on May 7, 1998. The public comment period on the NPRM closed on July 6, 1998.

The comments are being analyzed and HHS will publish a Final Rule in the Federal Register. The Final Rule will announce the standard.

o **Check Digit Formula for the National Provider Identifier**

The eighth position of the National Provider Identifier (NPI) is a numeric check digit. The check digit assists in detecting transposition and transcription errors in the NPI and in determining if the 8-digit identifier is a valid NPI. View the formula used to calculate the check digit.

o **Standard Record Format for the National Provider System**

This is the format through which we propose the National Provider System will:

- Accept an initial load of providers from an enumerating organization
- Communicate the crosswalk from NPIs to other corresponding provider numbers
- Communicate updates of provider records

Available formats:

1. Adobe Portable Document File (.PDF) Format **(RCFM1097.PDF 192K)**
2. WordPerfect 6.1 for Windows in self-extracting (.EXE) PKZIP (TM) Format **(RCFM1097.EXE 75K - 366K when uncompressed)**

o **Error/Warning Code List for the National Provider System**

This is the list of error and warning codes which may cause a file to be rejected or a health care provider to be pended instead of enumerated, or may result from incorrect, inconsistent, or missing data. These codes are based on the design of the NPS and NPF as described in the NPRM.

o **Frequently Asked Questions about the National Provider Identifier**

HCFA has received and responded to a number of questions concerning the National Provider Identifier and its implementation. Many of these questions were answered in the NPRM. Final resolution of many of these issues cannot occur until the Final Rule is published. We have compiled a list of the most frequently asked questions (FAQs) along with their answers. This list is updated on an ad hoc basis. View the FAQs.

o **List of Commenters on the NPI NPRM**

This is the list of organizations and individuals who sent comments on the NPRM. The comments are available to the public from the DHHS administrative simplification website. That address is http://aspe.os.dhhs.gov/admnsimp/

View the List of Commenters on the NPI NPRM.

Go to the Table of Contents

E-mail any questions concerning the National Provider Identifier to MEDICARESTATS@HCFA.GOV. In the subject of the e-mail, please put the words “National Provider ID” without the quotes.

<--- Go to the HCFA Initiatives

Last updated: February 24, 1999

LIST OF
COMMENTERS ON THE NATIONAL PROVIDER IDENTIFIER
NOTICE OF PROPOSED RULEMAKING

Federal Government or Quasi-Federal Government

Centers for Disease Control & Prevention

Department of Defense, Office of the Assistant Secretary for Defense, Health Affairs

Department of Justice, Drug Enforcement Administration

Department of Veterans Affairs

National Committee on Vital and Health Statistics

Panel to Evaluate the U.S. Standard Certificates c/o National Center for Health Statistics

State Government Organizations

National Association of State Medicaid Directors

Alabama Department of Public Health

Alabama Medicaid Agency

California Department of Health Services

Delaware Medical Assistance Program

Idaho Medicaid

Indiana Family and Social Services Administration

Kentucky Medicaid

State of Kentucky

State of Michigan, Medical Services Administration

Minnesota Department of Human Services

Missouri Department of Economic Development, State Board of Nursing

Missouri Medicaid

Montana Department of Public Health and Human Services

State of New Jersey, Department of Human Services

State of New York, Department of Health

New York State Office of Alcoholism and Substance Abuse Services

New York State Office of Mental Health

Ohio Department of Human Services

Pennsylvania Department of Public Welfare

South Carolina Medicaid

State of South Dakota

Texas Medicaid

Utah Medicaid

State of Washington Medical Assistance Administration

State of Washington Interagency Quality Committee

State of Wisconsin Department of Health and Family Services

Other State Organizations

Medical Association of the State of Alabama

California Information Exchange (CALINX)

California Mental Health Directors Association

Illinois Hospital and HealthSystems Association

Massachusetts Health Data Consortium and Affiliated Health Information Networks of New England
Health System Minnesota

Minnesota Administrative Uniformity Committee/Minnesota Health Data Institute

Nebraska Association of Hospitals and Health Systems
Nebraska Electronic Commerce Workgrouop

Home Health Services and Staffing Association of New Jersey

Healthcare Association of New York State

Utah Health Information Network

Medical Society of the District of Columbia

Blue Cross/Blue Shield Organizations

Blue Cross Blue Shield (BC/BS) Association

BC of California

BC/BS of Delaware

BC/BS of Florida

Hawaii Medical Services Association

BC/BS of Illinois

BC/BS of Kansas

BC/BS of Maryland

BC/BS of Massachusetts

BC/BS of Minnesota

BC/BS of Montana

BC/BS of Nebraska

BC/BS of New Jersey

New York State Conference of BC/BS Plans (by HSP&M)

BC/BS of the Rochester Area (NY)

BC/BS of Western New York

Empire BC/BS (NY)
BC/BS of North Carolina

Capital Blue Cross (Pennsylvania)

Highmark, Inc. (dba Highmark BCBS and Pennsylvania BCBS) (Pennsylvania)

BC/BS of South Carolina

BC/BS of Tennessee

BC/BS of Texas

BC/BS of the National Capital Area (Washington, DC)

Other Organizations

Aetna/US Healthcare

Allina Health Systems

American Academy of Family Physicians

American Academy of Pain Medicine

American Academy of Pediatrics

American Association of Health Plans

American Chiropractic Association

American College of Surgeons

American Dental Association

American Health Information Management Association

American Medical Association

American Medical Directors Association

American Medical Informatics Association

American Osteopathic Association

American Pharmaceutical Association
American Psychological Association

American Society of Health-System Pharmacists

American Society of Internal Medicine

Association For Electronic Health Care Transactions

Association of American Physicians and Surgeons, Inc. (National)

Association of American Physicians and Surgeons, Inc. (Arizona Chapter)

Brist Chiropractic

Cigna Healthcare (CN)

Citizens for Choice in Health Care (CCHC)

College of American Pathologists

Compaq, Industry Solutions - Healthcare

Delta Dental Plan of Illinois

Deseret Mutual

EDS (TX)

Electronic Healthcare Network Accreditation Commission

ENVOY Corporation

Federation of American Health Systems

The First Church of Christ, Scientist

First Health

Forum of ESRD Networks

HBO & Company

Harvard Pilgrim Health Care (Clinician Credentialing Department)

Harvard Pilgrim Health Care (Deputy Medical Director's office)
Health Insurance Association of America

Healthcare Financial Management Association

Healtheon

IMS Health

International Billing Association, Inc.

Joint Healthcare Information Technology Alliance

Kaiser Permanente

Mayo Clinic (Norby)

Mayo Clinic (Moertel)

Medical Group Management Association

Memorial Sloan-Kettering Cancer Center

NDC Health Information Services

National Association for Public Health Statistics and Information Systems

National Association of Chain Drug Stores

National Association of Health Data Organizations

National Board for Certification in Occupational Therapy

National Council of Prescription Drug Programs, Inc.

National Council of State Boards of Nursing

National IPA Coalition

National Medical Association

National Uniform Claim Committee

Northern Virginia Counseling Group

PCS Health Systems, Inc.
PM Group Life Insurance Company

PacifiCare Health Systems

Patient Choice Coalition

Physician Computer Network

Principal Financial Group

Private Healthcare Systems, Inc.

Rhea and Associates

St. George Consulting

St. Joseph Health System

Shared Medical Systems/Healthcare Data Exchange

State Farm

Society of Professional Benefit Administrators

Tufts Health Plan

UPMC Health Plan

United Healthcare Corporation

Upstate Medicare Division for the MCS Carrier Advisory and Change Board

Virginia Commonwealth Univ. and Medical College of Virginia Hospitals

Washington Chiropractic Trust

Workgroup for Electronic Data Interchange

Weyco, Inc. By Lancour & Assocs.

Xact Medicare Services

Individuals Whose Comments Do Not Indicate Organizational Affiliation(s)

Akre, Fred
Archer, John
Bailey, Bruce
Beasley, Michael
Beier, Barbara
Bianchi Dr.
Bittner, Mrs. Larry
Cadigan, Dan
Cavanaugh, Carolyn
Cento, Michael
Coats, James
Croft, Thomas
Davis, Karsten
Derer, Rick
Deuser, Kurt
Driscoll, Linda
Echols, Clark

El-Refai, Fouad
Effrem, Karen
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Ferguson, Marilyn
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Ford, Jay
Fort, Edward
Gordon, Robert E.
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Herold, James
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Schwartz, Ann
Shiel, Walt
Sokarda, Ted
Solesky, Edward
Spring, Nicole
Staiger, Linda
Strother, Bettye

Strunk, Jeff
Swanson, Dave
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Viele, Garry
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