



November 7, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Weems:

Thank you for your response to our letter dated September 11, 2007 outlining concerns we have regarding the National Provider Identifier (NPI). The American Medical Association (AMA) and Medical Group Management Association (MGMA), however, are concerned that significant implementation problems persist five months into the Medicare's NPI contingency. We would like to take this opportunity to raise additional issues and offer the following four recommendations that we believe, if adopted, would assist practitioners transition more smoothly to this new identifier:

1. Implement a rapid and direct outreach plan with a special emphasis on small and rural practitioners;
2. Allow the carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections;
3. Reconsider the revalidation process that began in October until the enrollment problems associated with Medicare NPI matching problems are thoroughly resolved; and
4. Carefully monitor and assess the industry's overall ability to use only NPI numbers by May 22, 2008, particularly the readiness of Medicare and those billing Medicare, before terminating the contingency plan.

The AMA and the MGMA are deeply concerned about Medicare's ability to appropriately "match" a physician's NPI number(s) to the appropriate legacy number(s); the requirements being placed on many practitioners to re-enroll; significant claims rejections practitioners are experiencing when there is a mismatch; and an overall lack of early and consistent information. With approximately seven months left until the May 22, 2008 NPI contingency plan deadline arrives, immediate outreach to physician practices is needed in order to avert further claims processing interruptions.

Until recently, when an appropriate match could not be made between a physician or group NPI to the appropriate legacy number(s) in the internal Medicare “crosswalk file,” Medicare would pay the claim. Beginning September 3rd through the end of October, the Medicare carriers began putting NPI systems edits into place. We appreciate that Medicare, rather than electing to do a hard “cut over,” chose to phase in the edits. Nonetheless, as you are aware, this has caused a significant number of claims to be rejected when a match cannot be made. Claims rejections spiked in some cases to more than 10% at carriers following the initial activation of the NPI edits. Although the matching problems in many cases were able to be resolved, a significant number of claim rejections are still occurring and we continue to receive numerous complaints. There can be significant financial implications for a single practitioner or small group practice who experience matching problems and the resultant claims rejections.

We are also concerned with the assertion made in your October 12th letter to us that practices were notified “three months ahead of the (crosswalk) bypass being lifted.” While some practitioners received informational error codes on their remittance advice this summer, they were poorly explained, and insufficient outreach was completed. As a result, many recipients of this information did not fully understand their significance. We have been alerted to numerous situations in which practitioners received no error codes on their remittance advice but, nonetheless, are experiencing significant claims rejections resulting from matching problems. In addition, as explained in your October 12th letter, “contractors were directed to provide at least seven days advance notice of the bypass edits being lifted along with pertinent information to assist physicians and providers.” One week notice, or even two, was simply not enough time to prepare practitioners, especially given the widespread misunderstanding of the significance of the informational edits. Furthermore, this did not give us an adequate amount of time to utilize our own internal communication channels before the edits went live.

Furthermore, single, incorporated practitioners continue to see significant matching problems and claims rejections. Efforts aimed at informing these practitioners early on that they needed an NPI, both for themselves and their corporation, was slow coming and inconsistently communicated. Frequently, these practitioners learned they needed two NPIs only after submitting an enrollment or change to enrollment application. Moreover, due to the way carriers enrolled single, incorporated practitioners in the past, an untold number of these practitioners were only assigned an individual PIN. It was not until after Medicare activated the NPI edits earlier this fall that single, incorporated practitioners with one PIN were instructed by Medicare to re-enroll to obtain a group PIN if they plan on billing Medicare with their Type II (corporate) NPI. We are unaware of any widespread outreach done on this prior to this time. We are also concerned that Medicare chose to wait to address these issues with practitioners until after the NPI compliance deadline – a decision which has complicated an already difficult transition.

The Medicare matching problems have been exacerbated by significant confusion surrounding what is expected of practitioners. In many cases, when practitioners have called their carriers for assistance with matching problems or for information on why their claims rejected, many are either unable to get through or the information regarding necessary enrollment steps they must take have not been readily forthcoming and often inconsistent. While some carriers have begun conducting outreach when matching

problems have been identified, much of this has happened only very recently. This type of targeted outreach was needed months ago, and Medicare should have instructed carriers to initiate direct contact with practitioners on these issues sooner. We also believe that significant matching problems have ensued as a result of earlier carrier PIN enumeration policies. Medicare's solution to this is for practitioners to re-enroll, a highly burdensome process that adds to already stressful situation when claims are not processing. Despite the advance notice concerning Medicare's recent decision to require NPI or NPI/legacy pairs on claims beginning March 1, 2008, we are concerned that this may not be a sufficient amount of time for practitioners who have been asked to re-enroll.

With respect to our concerns described above, we have four recommendations. **First, we strongly urge CMS to work quickly to implement a rapid and direct outreach plan with a special emphasis on small and rural practitioners.** This plan should include monthly phone calls for representatives of state, specialty and national organizations that represent practitioners. CMS should, in a timely manner, share clear and concise information impacting any future interim steps leading to the termination of their contingency plan. With Medicare's recent announcement that legacy only numbers will not be permitted on Part B claims after March 1, 2008 as well as the confusion surrounding the earlier information matching edits, we strongly urge Medicare to include more descriptive messages on remittance advice alerting practitioners when their NPI is missing and to the March 1 date. CMS should also host an increased number of roundtables to field questions, gauge readiness, and share information on Medicare's transition to the NPI. Continued direct carrier-to-practitioner contact is needed in order to resolve the matching problems. CMS should deploy additional, fully-trained, carrier enrollment and customer service staff to deliver prompt and consistent answers. As one example, NHIC, the carrier in Northern California, has assembled an internal team to troubleshoot physician NPI issues. Proactive steps like these are needed at every carrier.

Second, given the fact that an untold number of practitioners are being asked to re-enroll, we urge Medicare to allow the carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections. We recognize and continue to communicate to our members the importance of a complete 855 enrollment application. Nonetheless, carriers need greater latitude in processing enrollment applications so as to avoid the 90 plus day backlogs seen at many carriers following the new enrollment process established in May 2006. Specifically, we urge Medicare to remove the rigid pre-screening process required under the current guidelines and revert back to the process in place prior to May 2006. This will allow for a more open exchange of information between carriers and practitioners and keep the enrollment process moving along. CMS should employ flexibility when minor errors or omissions are found on a physician's enrollment application.

Third, we strongly urge Medicare to reconsider the revalidation process that began in October until the enrollment problems associated with Medicare NPI matching problems are thoroughly resolved, as this will place further burden on an already strained enrollment process. Any revalidation efforts should be halted and resumed only after a web-based enrollment system is up and running. The current revalidation efforts began without appropriate education and little advance notice. It is unclear whether the previously identified communications problems between carrier provider

enrollment personnel and practitioners have been resolved. Without any assurances that this problem has been resolved, there is no way of ensuring that the appropriate personnel in each practice have received the revalidation letters. Given the significant penalties for failure to respond in a complete and timely fashion, it is critical to ensure that the current communication channels are functioning. Additionally, most medical groups, especially smaller ones, do not have dedicated enrollment staff whose sole function is to complete and process credentialing applications. Instead, most practices have one individual whose responsibilities include credentialing when necessary, which may be once every two or more years. This will result in the form taking additional time with increased potential for errors. Thus many practitioners will be completing new 855 applications to revalidate at the same time other practitioners are required to complete new 855 applications, leading to increased backlogs.

Lastly, we strongly urge CMS to carefully monitor the industry's overall ability to use only NPI numbers by May 22, 2008, particularly the readiness of Medicare and those billing Medicare. In making this determination, consideration must be given to how ending the contingency plan will impact those who may be entwined in the Medicare enrollment process and practitioners' ability to successfully submit claims to commercial payers. Practitioners have been working hard to become NPI compliant and we are pleased to learn that according to your figures, 84.78 Medicare Part B claims are being submitted with an NPI. However, the implications for terminating the contingency plan too soon could be especially crippling to some. Given the Medicare matching problems and the fact that many practitioners have had to revert back to using legacy numbers alone to get paid, we strongly encourage you to permit practitioners' use of legacy numbers only through the end of the contingency period.

In order to facilitate the appropriate internal matching needed in order for their claims to be processed, practitioners rely on information provided to them by their carriers. However, with a transition of this complexity, it is critical that practitioners receive clear information as soon as possible and that Medicare provide the carriers the appropriate resources and enrollment flexibility needed during this transition. We appreciate the opportunity to bring these concerns to your attention and your willingness to work with the physician community to ensure that the transition to the NPI goes as smoothly as possible. If you have any questions regarding our concerns, please contact Mari Savickis at mari.savickis@ama-assn.org or (202) 789-7414 or Robert Tennant at (202) 293-3450, ext. 1373 or rmt@mgma.com.

Sincerely,

American Medical Association
Medical Group Management Association