Physicians Are Hoping for a CMS Revision on NPI Numbers

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Contributing Writer

WASHINGTON — The Centers for Medicare and Medicaid Services will review national provider identifier protocols that now require separate numbers for each covered entity. The requirement could mean some physicians who are also part of group practices and other arrangements would have multiple NPI numbers.

At a meeting of the Practicing Physicians Advisory Council, members brought the issue to the attention of CMS's director of program integrity, Kimberly Brandt.

"The goal here was to have less numbers, not more. So I appreciate your point, and it's a very good one. And that's something I will definitely look into," Ms. Brandt said.

PPAC member Barbara McAneny, M.D., an oncologist from Albuquerque, suggested the review as part of a draft recommendation approved by the council. The recommendation suggests CMS clarify which current provider numbers would be replaced by the NPI number and which entities would need their own numbers.

Dr. McAneny also suggested CMS "put pressure" on other groups, including state licensure boards, "to eliminate some of the numbers."

NPI enrollment began May 2 and continues through May 2007, when providers will be required to use the system for standard electronic health care transactions.

"With national standards and identifiers in place for electronic claims and other transactions, health care providers will be able to submit transactions to any health plan in the United States," CMS Administrator Mark McClellan, M.D., said in a May letter to health care providers. "Health plans will be able to send standard transactions such as remittance advices and referral authorization to health care providers."

As a requirement of the Health Insurance Portability and Accountability Act, many health plans—including Medicare, Medicaid, private health insurance issuers, and health care clearinghouses—must use NPIs in standard transactions by May 2007. Small health plans have an additional year to comply. The number is intended to replace current numbers, including the unique physician identification number (UPIN).

Ms. Brandt told the advisory council that CMS is conducting a "massive outreach effort" to inform providers of the change and encourages them to apply for an NPI. Applications can be made electronically or through the mail.

To demonstrate the process of getting an NPI, PPAC Chairman Ronald Castellanos, M.D., got his number at the council's meeting, in a process that took approximately 8 minutes.

"I'm not bleeding," Dr. Castellanos said when asked how painful the process was.

PPAC member Geraldine O'Shea, D.O., an internist who practices in Jackson, Calif., also tried the NPI application process. She found that it "took some effort" and was more complicated than she expected.

"It appeared to be pretty simple, but you had to have many numbers available for the filing," including a state license and a Medicare identifier. Dr. O'Shea said.

CMS is encouraging health plans to devise a transition plan for a system that accepts both the UPIN and NPI until the May 2007 compliance deadline. Ms. Bryant said that although a few health plans already have systems developed, most do not—including Medicare, which she said will not have the "capacity to be fully changed over" until 2007.

CMS is recommending that members of groups not sign up individually now but wait until fall, when "batch enumeration" systems will be in place to accept group applications.

Once assigned a random NPI, providers will have that number for the remainder of their careers. The system will be meshed with Social Security information to track provider deaths, and the agency hopes to be able to coordinate with state licensing groups as well, Ms. Brandt told the council. ■

Please, May We Have a Directory?

Security concerns are currently keeping CMS from developing a directory of all NPI numbers for all health providers and covered entities, but one may be developed in the future, Ms. Brandt told PPAC members.

"We may get to a point where we have a directory, but right at the moment, we don't have a [list] like the unique physician identification number directory in the works," she stated.

Instead, the agency is planning to publish in the Federal Register in October a notice on how NPIs can be obtained from other health care providers and covered entities.

PPAC members encouraged Ms. Brandt to look into a directory for referring physicians, even if it's a subscriber service.

"I would strongly advocate that you [develop a directory] even if there's a subscription fee because one of the more problematic things when you bill for a consult is to try to track down Dr. Jones' [UPIN], and it's a significant hurdle and a big burden on the practice," said surgeon Anthony Senagore, M.D., of the Cleveland Clinic Foundation.

Ms. Brandt noted that an encrypted or password-accessed system would be necessary, given that "people have been able to get access to [the UPIN directory] who shouldn't have been able to get access to it." Council members' recommendation for a subscription fee or encryption is "a good one," she said.

POLICY & PRACTICE

Doctors and Politics Do Mix?

The American Academy of Dermatology Association is advocating for physicians serving in the U.S. Senate to be allowed to continue to practice medicine.

Senate Rule 37 prohibits senators from affiliating with "a firm, partnership, association, or corporation for the purpose of providing professional services for compensation." Although the rule addresses professional services for compensation, it would prohibit physicians in the Senate from maintaining not-for-profit medical practices, according to the AADA.

The AADA, a sister organization to the American Academy of Dermatology, along with 11 other medical associations, wrote to the U.S. Senate Rules and Administration Committee urging it to change the policy. "Unlike many other professions, physicians require continuing, hands-on experience to maintain their skills," the groups wrote. "This is essential, since a lawmaker returning to the private sector cannot simply 'pick up where he left off.' "

Psoriasis Research Support Urged

Support for federal research on psoriasis seems to be growing. Twenty-five members of Congress recently circulated a letter to their colleagues urging increased psoriasis funding in next year's National Institutes of Health budget. And last month, the House approved language as part of the report that accompanies its NIH appropriations bill calling on the agency to support research on psoriasis.

The language supported increased research within the National Institute of Allergy and Infectious Diseases, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, the National Center for Complementary and Alternative Medicine, and other NIH institutes. At press time, the bill was still being considered in the Senate.

NIH Extends Disclosure Deadline

Officials at the U.S. Department of Health and Human Services are giving NIH employees more time to report prohibited financial interests and to divest stock. In announcing the extension, HHS wrote it is considering issuing revisions to its current ethics regulations.

In February, the agency issued regulations prohibiting NIH employees from engaging in consulting relationships with organizations that are substantially affected by NIH decisions. And NIH employees who are required to file financial disclosure statements are prohibited from acquiring or holding stocks in these affected organizations. NIH employees now have until Oct. 3 to file financial disclosure reports and until Jan. 2, 2006, to divest of prohibited financial interests. This is the second extension offered to NIH employees.

Sleep Deprivation Dogs Doctors

Residents and medical students are still suffering from fatigue, despite the shorter work hours established in 2003 by the Accreditation Council for Graduate Medical Education. In a survey of 1,126 medical students and 1,010 residents, the American Medical Association found that 44% of residents and 39% of medical students said they've experienced sleep deprivation about once a week or more often during their most recently completed rotation.

The ACGME work limit is 80 hours per week, but 11%-12% of the respondents said their workweek exceeded those hours on their most recent rotation. Nearly half of the respondents thought that sleep deprivation or fatigue may have had a negative impact on the quality of patient care they delivered.

Medicare Drug Benefit Explained

The Centers for Medicare and Medicaid Services is requiring all health plans serving Medicare patients to include all drugs in six categories on their formularies starting in 2006, when the Part D drug benefit begins. The agency noted that in earlier guidance on the Medicare drug plan, it stated that "a majority" of drugs in these categories—antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressants, and HIV/AIDS drugs—would have to be on plan formularies and that beneficiaries should have uninterrupted access to all drugs in those classes.

But in training sessions and in answering user calls, "CMS has consistently explained that this meant that access to 'all or substantially all' drugs in these specific categories needed to be addressed by plan formularies," the agency said. "This is because the factors described in our formulary guidance indicated that interruption of therapy in these categories could cause significant negative outcomes to beneficiaries in a short time frame."

DEA Battles OxyContin Abuse

The Drug Enforcement Administration's efforts to stop illegal use of the prescription painkiller OxyContin have "cast a chill over the doctor-patient candor necessary for successful treatment," Ronald T. Libby, Ph.D., a political science professor at the University of North Florida in Jacksonville, wrote in a policy analysis for the Cato Institute, a libertarian think tank.

The DEA's campaign includes elevating OxyContin to the status of other schedule II substances and using "aggressive undercover investigation, asset forfeiture, and informers," he noted. "The federal government has made physicians scapegoats for the failed drug war," he wrote. When asked for comment, a DEA spokeswoman referred to a recent statement by DEA Administrator Karen Tandy. "We employ a balanced approach that recognizes both the unquestioned need for responsible pain medication and the possibility … of criminal drug trafficking," Ms. Tandy said, noting that physicians "are an extremely small part of the problem."

—Mary Ellen Schneider