
**WEDI Strategic National Implementation Process (SNIP)
SNIP Transactions Workgroup
National Provider Identifier Sub Workgroup**

HIPAA National Provider Identifier White Papers



National Provider Identifier (NPI) - Overview and Educational Reference Guide

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The NPI Registration Process

I. Scope

This paper is designed to provide an overview of the National Provider Identifier (NPI), its structure, purpose and potential impacts. Since provider identifiers form the heart of the healthcare reimbursement structure and systems, successful implementation of the NPI within provider and payer organization is crucial to maintaining cash flow and financial health.

The National Provider Identifier (NPI) is the result of the mandate in the 1996 Health Insurance Portability and Accountability Act (HIPAA) that the Secretary of HHS establish a standard national provider identifier. This new identifier, the NPI will replace many existing national (e.g. UPIN), state (Medicaid), and proprietary (individual hospital, healthcare system, commercial payer) provider identifiers. Though all healthcare providers will be eligible to receive NPI's, covered healthcare entities will be mandated to use the NPI as the sole provider identifier on all HIPAA electronic transactions¹. The 10 digit number will be assigned by a CMS funded NPI "Enumerator" through the NPPES (National Provider and Plan Enumeration System)

The principal characteristic of the identifier is that the number will contain no logic or identifying information relating to the location of the provider, type of provider, services able to provide, etc. Each individual provider will have one and only one NPI regardless of practice locations or settings. Healthcare providers who are organizations may designate components of the organization as "subparts". The subparts may obtain their own NPI's and are considered organization healthcare providers. However there will be nothing in the NPI number itself or in the NPPES system that will link a subpart to its "parent"². This type of identification system is often different for the internal and external systems of healthcare providers and payers that may depend on logic embedded in the provider number for producing bills, paying claims and other external standard transactions.

Healthcare providers will be able to apply for NPI's starting in May 2005. Though the NPI will not be mandated as the sole identifier to be used in standard transactions with most health plans until May, 2007(May 2008 for small health plans) there are many changes necessary within health plans' (including Medicare, Medicaid and Commercial Plans) and organizational healthcare providers' systems that will necessitate that providers have NPI's as early as possible in order to meet the compliance deadlines.

¹ Providers that do not furnish healthcare (as defined in 45 CFR 160.103) are not eligible for NPI's. An example might include taxi drivers who are not healthcare providers, but whose services are sometimes paid by healthcare payers such as Medicaid. This is explored further in [NPI Registration](#) white paper.

² The term subpart is in some ways a misnomer. The organizational component designated as a subpart has no "sub"servient relationship or link to the parent organization. The "subpart" has the same status as any other NPI. There is nothing that indicates or implies that one NPI is different or "less than" another.

Thus, the “NPI” represents not only a new identifier but also impacts processes and may require significant systems changes. As the NPI and the NPES system are new, education, capture and submission of NPI data, enumeration, and building of cross-references to legacy identifiers has not been actually undertaken. Since the provider identifier and processing is at the heart of the billing and claims payment processes for every healthcare entity, successful implementation of the “NPI” and its use in internal systems and external transactions is essential for continued reimbursement and provision of care.

Many in the industry have indicated that the changes will have a substantial effect on their internal and external transactions. Many questions have been raised and issues identified. This document is intended to provide a road map of the current assessment/analysis of the impacts and issues. It will also review some recent history so that issues are not re-visited if addressed in a previous or ongoing work. As such, it is a changing dynamic document that evolves with the information provided by CMS, the development of other WEDI-SNIP white papers and other industry sources.

It references other documents and sources that provide an overview, frequently asked questions and then provides references for delving into specific issues related to the NPI enumeration process, use of the NPI, dissemination of data, impact analysis and implementation.

II. Background

What makes the NPI important and its implementation an issue? The long-term goal is to allow interoperability of a standard identifier for providers across a multitude of commercial and government providers and payers. Tracking quality results for individual practitioners across multiple institutional and payer environments becomes possible. The standard identifier is a key component in the ability to have any interoperable electronic medical record. However in order to reach the administrative simplification benefits, changes within the healthcare providers and payers internal/external information systems and business processes will have to change.

Other HIPAA standards implementations have shown the benefit of analyzing not only the information systems within each institution, but also the business processes that depend on provider information and the external relationships where provider data is transferred. Organizations therefore need to not only look at their means for capturing, maintaining NPI data, but also other crucial data not identified within the NPES such as multiple practice locations, group practice relationships, hospital affiliations, payer affiliations/participation, organizational relationships, component “sub-part” relationships, etc. Most providers, health plans will continue to capture and maintain this data for their strategic planning/network development, credentialing, marketing, scheduling, contracting and other processes.

At a glance, the mandated implementation date in May 23, 2007 seems far removed. However even in the fall of 2004 many organizations from the American Hospital Association to WEDI were urging members that fall 2004 was almost past the time to begin NPI systems/impact evaluations and place the Project implementation team in place. Since

systems changes and implementation time frames of both internal and vendor may have a 12-18 month lead-times, the 2007 time frame approaches quickly.

After a brief overview, the series of questions about the NPI and its implementation are discussed and the WEDI white papers that address them are indicated. As they are approved and updated, this paper will be linked to them for issue updates and review.

III. CMS References and Information

A. Overview of the National Provider Identifier (NPI) Final Rule – January 23, 2004

This overview written by CMS's Office of HIPAA Standards provides the key points, dates and constraints of the NPI final rule.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard unique health identifier for healthcare providers.

On January 23, 2004, HHS published the Final Rule that adopts the National Provider Identifier (the NPI) as the standard unique health identifier for healthcare providers. The effective date of the rule is May 23, 2005, 16 months after its publication date. Healthcare providers may apply for NPI's beginning on the effective date.

The compliance date for all covered entities is May 23, 2007, except that small health plans do not need to comply until May 23, 2008. When the NPI is implemented, covered entities will use only the NPI to identify healthcare providers in all standard transactions. Legacy identification numbers (e.g., UPIN, Blue Cross and Blue Shield Numbers, CHAMPUS Number, Medicaid Number, etc.) Will not be permitted. Healthcare providers will no longer have to keep track of multiple numbers to identify themselves in standard transactions with one or more health plans. However, the Taxpayer Identifying Number may need to be reported for tax purposes as required by the implementation specifications.

The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit in the 10th position. It is accommodated in all standard transactions, and contains no embedded information about the healthcare provider that it identifies. The assigned NPI does not expire; and at the current rate of healthcare provider growth, can continue to be assigned for 200 years.

All healthcare providers, as defined in 45 CFR 160.103, are eligible for NPI's. Healthcare providers who transmit any health information in electronic form in connection with a transaction for which the Secretary has adopted a standard are covered entities (45 CFR 160.103) and are required to obtain and use NPI's. Healthcare providers who are not considered covered entities may also apply and be assigned an NPI. However, entities that do not provide healthcare (e.g., transportation services) are not eligible to be assigned NPI's because they do not meet the definition of "healthcare provider" and are not subject to HIPAA regulations.

In certain situations, it is possible for “subparts” of organization healthcare providers (such as hospitals) to be assigned NPI’s. These subparts may need to be assigned NPI’s in order to conduct standard transactions on their own behalf or to meet Federal regulatory requirements related to their participation in health plans such as Medicare. The Final Rule requires covered healthcare providers to determine if they have subparts that may need NPI’s and, if so, to obtain NPI’s for the subparts or require the subparts to obtain their own NPI’s. The subpart concept does not pertain to healthcare providers who are individuals.

Healthcare providers will be assigned NPI’s upon successful completion of an application form. The form can be submitted on paper or over the Internet. Once a healthcare provider has been assigned an NPI, it must furnish updates to its data within 30 days of any changes.

The National Provider System (NPS), being built under a Centers for Medicare & Medicaid Services (CMS) contract, will process the applications and updates, ensure the uniqueness of the healthcare provider, and generate the NPI’s. The NPS will be able to produce reports and information based on requests from the healthcare industry and others.

A single entity, known as the enumerator, and performing under a CMS contract, will operate the NPS. The enumerator will receive applications and updates from health care providers. The enumerator will assist health care providers in completing applications and in furnishing updates, and will be responsible for resolving problems and answering questions. The enumerator will notify the health care providers of their NPI’s. The enumerator will also process requests for, and disseminate information containing, health care providers’ NPI’s. HHS will prepare a Federal Register Notice describing the NPS data dissemination policy.

Information about NPI implementation, including information on how to apply for NPI’s, will be made available to the health care industry by CMS closer to the effective date

This document is also available at:

<http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/NPI-FR-GeneralOverview-REV-2-18-04.pdf>.

B. NPI Final Rule

The entire final NPI rule was published in the Jan 24, 2004 Federal Register. Though it is not reproduced here, it can be accessed at:

<http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf>

C. CMS FAQ about the NPI

This link will query CMS’s web site for many Frequently Asked Questions (FAQ) related to the NPI. It creates a query that produces all of the NPI related FAQ’s. The actual web address/ query link is:

[Direct link CMS FAQ that relate to NPI](#)

D. NPI Enumerator Contract – RFP and Scope of Work

As indicated in the Overview and the NPI Rule, the enumeration of providers will be accomplished using the National Provider and Plan Enumeration System (NPES). CMS will contract with a vendor to operate this system and manage the enumeration, data dissemination and maintenance process for the NPI. The actual RFP was released in October 2004. The solicitation, scope of work, and the subsequent amendments outlines the overall processes and responsibilities of the enumerator. It provides an insight into the NPES systems design and the process flow of the enumeration operation. There are also CMS responses to questions posed by both vendors and interested parties.

Though there are certain portions of the documents and many questions that are specific to the contracting process, many differing items addressed offer valuable insights into the enumeration process and assumptions. It can be found at:

<http://www.eps.gov/spg/HHS/HCFA/AGG/RFP%2DCMS%2D2005%2D0004/Attachments.html>

The Enumerator contract was awarded to FOX Systems, Inc., 6263 North Scottsdale Road, Suite 200, Scottsdale, Arizona 85250. The actual award document can be viewed at:

http://fs2.eps.gov/EPData/HHS/Synopses/3305/RFP-CMS-2005-0004/1_AWARD.doc

IV. Industry Issues & Impacts – WEDI NPI Policy Advisory Group (PAG)

In the spring of 2004, after the publication of the NPI Rule in January, WEDI SNIP set up a NPI sub-group in order to investigate the implications, issues and questions surrounding the NPI. The first task of this sub-group was to identify the types of issues surrounding the NPI – questions, areas of impact, etc. The outcome of this work is the document shown in Appendix A.

On June 22nd and 23rd of 2004 WEDI held a Policy Advisory Group (NPI-PAG) in Crystal City (Arlington) Virginia. Following overviews of the NPI, what it is and is not from CMS, the NPI-PAG used the issues document in Appendix A as discussion springboards for different workgroups related to Enumeration, Implementation and Regulations. The general session then reviewed these issues and made recommendations to the WEDI board. The WEDI board submitted the resulting finalized recommendations to the HHS secretary in September of 2004. These recommendations are available at:

<http://www.wedi.org/cmsUploads/pdfUpload/commentLetters/pub/093004NPIFinalEDJR.pdf>

A second WEDI NPI-PAG was held in Atlanta in November 2004, just prior to the WEDI Fall Conference. The official results, minutes and recommendations of this NPI-PAG have not been released yet. This document will be updated to reflect those recommendations.

In addition the NPI-PAG in conjunction with the WEDI-SNIP board has identified several areas where detailed study and investigation by industry representatives can help lessen the education and implementation burden on individual institutions. Equally important the detailed interaction at the task group/ white paper level unearths potential issues and solutions before they actually happen.

Ongoing work about many issues is discussed on an ongoing basis through WEDI-SNIP's NPI list-serve. To sign up for the list serve go to <http://www.wedi.org/listserve>. Specific questions can also be directed to the NPI Sub-Group co-chairs. Peter Barry (peterbarry@aol.com) or Walter Suarez (walter.suarez@sga.us.com). In addition they can inform you of the regular conference calls and on-going work.

V. WEDI NPI Sub Group White Papers

What is the NPI? How will a provider obtain an NPI? Will the process be different for an individual versus an organization, etc? These and a host of others are asked daily throughout the industry. The different white papers that respond to these questions are identified below. The contact email addresses are shown for each of the White Paper Co-leads at the end of each section. For further information or to volunteer for their workgroup contact either of the co-leads. (Also for CMS direct responses to [Frequently Asked Questions related to the NPI](#))

A. NPI Registration Process:

- Co-Lead: Charlie Waldhauser, CMS - CWaldhauser@cms.hhs.gov
- Co-Lead: Walter Suarez, MCHE – walter.suarez@sga.us.com

How will providers be enumerated? Are there different methods? Who is eligible? Can someone else apply for a provider? How will providers receive their NPI's? How long will the Process take?

The NPI Registration Paper addresses who is eligible for NPI's. Though it talks in detail concerning NPI's for individuals, there is also a separate paper on "NPI Sub-Parts" that takes an in depth look at how an organization healthcare provider may determine whether NPI's should or must be assigned to portions or parts of the organization.

The paper reviews the three processes, Paper Application, Internet/On-Line Application, and Electronic File Interchange (EFI...referred to as "bulk enumeration in the NPI Final Rule) that will be allowed. The data elements that need to be collected are outlined and examples of completed paper applications are shown as well.

B. Identification of Subparts for Designation and Use of NPI

- Co-Lead: Gail Kocher – Highmark - gail.kocher@highmark.com
- Co-Lead: John Bock - jbock@prodigy.net
- Co-Lead: Suzanne Ronde – Aurora Health Care - suzanne.ronde@aurora.org

What are “sub-parts”? What portions of an organization must obtain an NPI? When an NPI is not required by Federal law, what business decisions may affect whether another NPI is needed? What discussions should a provider have with their primary payers before making the decision?

NPI's for Sub-Parts of an organization appears to be one of the most difficult portions of the NPI rule for many people to understand and determine what the requirements are and when a portion of an organization may/should have an NPI. This paper will address these issues and produce guidelines for the decision process.

Because of the name “sub-parts”, some in the industry have the impression that a subpart obtains an NPI that is subsidiary to the parent organizations “main NPI”. No such relationship exists within the NPPES system. No organizational NPI has a different format from another. The NPI assigned to the “sub-part” is not different from or “subservient” to the NPI assigned to the “parent”. There is no hierarchal or parent/child relationship between numbers within the NPPES system.

C. NPI Impact on Healthcare Providers

- Co-Lead: Michael Apfel – Truman Medical Centers -Michael.Apfel@tmcmcd.org
- Co-Lead: Barbara Gerke – Carondelet Health - bgerke@carondelet.com

What is the impact on provider organizations? What issues should be addressed in developing an NPI project plan? How will the NPI be used for a pharmacy or chain of pharmacies? What are the needs of the various types of organizations Hospitals, Nursing Homes, Pharmacies, Outpatient Clinics, Group practices, etc.? What goes into the process of determining how the NPI impacts the organizations systems? What are different hospitals and health systems doing to help providers enumerate? Are there guidelines for educating individual healthcare providers?

This paper is one of three impact analysis papers for healthcare Providers, Payers, and Vendors and Clearinghouses, as indicated below. These papers focus on internal needs. Though there is some necessary overlap, the white paper on Timing, Sequencing and Implementation addresses the external requirements for implementation of the transactions between trading partners.

The Provider Impact identifies what is needed within the providers internal operations to continue to produce and receive standard transactions using an NPI. The paper addresses periods when the provider may have to support dual transactions based on whether or not an individual or other organization has received an NPI. It also identifies strategies that a provider may use to shorten the window in which it will have to process standard (and possibly other) transactions with dual identifiers.

D. NPI Impact on Payers

- Co-Lead: Charles Waldhauser, CMS - CWaldhauser@cms.hhs.gov
- Co-Lead: Hope Furtado, TM Floyd & Company, Hfurtado@tmfloyd.com

What will Health Plans do after NPI's are available in May? What transition options are there? How does the payer assure that they have the right NPI for a particular healthcare provider? What issues will drive the systems impact analysis? What might it cost? What additional information does a plan need, and from whom? What happens with authorization issued under a legacy ID and the provider switches to NPI? Etc.

Again this paper focuses on the impact to the health plans/payers operations internally. What are the parameters for determining the changes necessary to their systems? It identifies what internal and external information that they need in order to receive and send electronic and paper transactions that will contain the NPI.

Though there is some overlap with the Implementation white paper, the primary focus is the systems and business processes analysis necessary to plan and prepare to generate transactions and maintain business relationships.

E. NPI Impact on Clearinghouses and Vendors

- Co-Lead: Melanie Benson, CaremarkPCS - melanie.benson@caremark.com
- Co-Lead: Mary P. Griskewicz, IDX Systems Corporation - mary_griskewicz@idx.com

What unique issues exist for healthcare clearinghouses and vendors? What lead times do vendors require to have their systems changed? What happens when a provider is sending an NPI and the payer is not "capable" of receiving it? What additional issues are raised because of interaction between clearing houses and: Payers? Providers? Different classes of providers? Pharmacies? How will clearinghouses be included in the educational process? How will they be informed of enumerated providers?

Healthcare clearinghouses deal with a variety of provider and payer systems, including business rules (sometimes even for the healthcare service encounter). They need to know the internal changes they have to make, but as the "middle man" between providers and health plans, they need to know the timing and sequencing of the changes of their differing customers. This paper explores the internal issues related to the clearing house and examines the external communications needs between business associates that are required so that the clearing house is informed of the status and changes in business processes at each of its business associates. Where possible the external needs for Implementation and sequencing are discussed in the Timing, Implementation and Sequencing white paper.

Vendors need adequate time to make and test appropriate software changes. Timing issues as well as the capture of specifications, development changes, testing and release multiple entities is also reviewed.

F. NPI Implementation: Planning, Testing, Sequencing and Timing

- Co-Lead: Lisa Schwenker, Blue Cross Blue Shield Association – lschwenker@bcbsa.com
- Co-Lead: Steve Witter, Folio Associates – switter@foliomed.com

How will HIPAA mandated transactions be affected? What essential communication and timing efforts exist between Providers, Payers and Clearinghouses? Are there preferred sequences for transaction implementation? On going education and communications needs? What is effect of timing of individual and organizational healthcare provider enumeration? What tasks are assumed completed prior to testing/implementation? Test with one submitter/payer or all? NCPCP Implementation sequence? Round trip testing? How to use dual identifiers? Shortening the dual processing / testing window?

The NPI Implementation: Planning, Testing, Sequencing and Timing white paper addresses the issues related to the interaction between trading partners. It outlines the assumptions of what has been completed within the Provider, Payer, Clearinghouse and Vendor organizations. It then focuses on the various implementation strategies and tactics for sending transactions between trading partners.

The paper examines the requirements/ assumptions associated with various transactions. It reviews those requirements to look at potential implementation sequences. It also discusses the issues involved in determining whether to implement with all submitters/payers or just one at a time.

G. NPI Dissemination

- Co-Lead: Durwin Day, Health Services Corp. (BCBS-IL) – Dayd@bcbsil.com
- Co-Lead: Leslie Harpe, South Georgia Medical Center – leslie.harpe@sgmc.org

How will healthcare providers know of their NPI's? What information will be available from the NPES for healthcare providers, payers, clearinghouses and others in the industry? For the general public? How will the data be accessed? When will the different access methods be available? Will it be possible to capture legacy identifiers from the NPES? Has there been any verification of the legacy ID's? If a change is found to the data, how can that be communicated to the NPES? How will NPI's received in transactions by providers, payers, clearinghouses, etc. be validated before the CMS data dissemination process is finalized and released?

The NPI Final Rule indicates that there will be different levels of access to the NPES data based on the needs of the different parties. The Enumerator and CMS will be the only ones with full access to all of the data. This paper identifies the rules and the necessity for different entities to use data. It outlines the process for data access approval. It details the differing data access methods.

Since CMS has indicated that the data dissemination portion of the system is not yet finalized, this section will be updated and modified when CMS publishes the Data Dissemination Notice in the Federal Register. In addition, it would be anticipated that someone from CMS would also sit on this workgroup, so that any questions and issues regarding access can be addressed when the system and regulations are being finalized.

H. NPI Electronic File Interchange (EFI) / Bulk Enumeration

- Co-Lead: Laurie Darst, Mayo – darst.laura@mayo.edu
- Co-Lead: Gail Kocher: Highmark – gail.kocher@highmark.com
- Co-Lead: Steve Witter, Folio Associates – switter@foliomed.com
- Co-Lead: Peter Barry, Peter Barry Assoc. – peterbarry@aol.com

What is bulk enumeration and electronic file interchange? What is the relationship between bulk enumerator and providers? What is the process for applying to become a bulk enumerator? What are the technical specifications of the EFI file, submission mechanisms, security, etc? What are the effects of different planning, testing and implementation timeline options? What happens after NPI Enumerator receives the EFI file. What are the response options from NPI Enumerator to bulk enumerator? What are the post-enumeration communication needs (and requirements) between bulk enumerator and providers?

The purpose of this white paper is to review the process and technical elements related to the NPI enumeration being done using the Electronic File Interchange (EFI) option, or Bulk Enumeration. This white paper builds upon the WEDI PAG recommendations on this topic and the general description of bulk enumeration presented in the NPI Registration white paper.

The Electronic File Interchange process will provide a means for electronic submission of enumeration requests. The process will also handle updates to the provider information maintained by NPPES. The Electronic File Interchange (EFI) will alleviate the need to have each of these healthcare providers individually submit a paper request to the Enumerator or logon to the NPPES web site to enter his/her own application manually.

EFI involves the ongoing/periodic submission of electronic files by provider organizations, regional collaboratives, associations, state agencies and others that contain data for multiple providers seeking NPI's. Data dissemination, for the purposes of this paper, will be limited only to response back to the bulk enumeration submitter and the submitter's subsequent reporting of NPI's to providers who authorized the bulk submitter to send an EFI enumeration request on their behalf.

VI. Acknowledgements

WEDI/SNIP would like to express its appreciation to the authors for their efforts in preparing this White Paper:

- Stephen C. Witter, Folio Associates - switter@foliomed.com

APPENDICES:

Appendix A - WEDI SNPI NPI Sub-WorkGroup Preliminary Issue Topics

- a. Issues Concerning the NPS System
- b. Issues Concerning Implementation
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- d. Issues Concerning Testing

WEB Reference:

http://www.wedi.org/snip/public/articles/dis_publicDisplay.cfm?docType=6&wptype=3

Appendix B - WEDI NPI Policy Advisory Group (PAG)

- a. PAG Meeting Materials – June, 2004

WEB Reference:

http://www.wedi.org/public/articles/dis_viewArticle.cfm?ID=273

- b. Letter of Recommendation from WEDI Board to HHS – October, 2004

WEB Reference:

http://www.wedi.org/public/articles/dis_viewArticle.cfm?ID=289

Appendix C - WEDI NPI Sub Group White Papers

WEB Reference:

http://www.wedi.org/snip/public/articles/dis_publicDisplay.cfm?docType=6&wptype=3