

**HIN User Group Meeting Minutes**  
**April 1, 2004**  
**Houston, TX**

**Introduction**

The HIN User Group met on April 1 at 9:00 am, chaired by Peter Hall. After introductions, Hall gave a brief summary of production activity at HIBCC. In the last period since December 5, 2003, HIBCC staff processed a total of 50,500 HIN requests. Approximately one-half of these were from the AHJ EDI Special Project. A summary of HIN request processing activity is shown below.

Source	HIN Requests	Assignments	Cross-references	Cancels
Human Health	50,500	35,850	10,478	4,172
AHI Project	26,343	20,256	4,181	1,906
<b>Total</b>	24,157	15,594	6,297	2,266

Currently, there is a total backlog of about 10,000 HIN requests in the queue, of which 11 are from the AHJ project. Hall announced that CD's from the first periodic HIN distribution for 2004 were shipped in early March.

**XML Update**

An XML schema is planned as a distribution enhancement for HIN. XML would be used for scheduled updates, HIN requests and HIBCC responses to HIN requests. XML would not replace EDI, but would be an additional means of communicating with HIBCC. The eBusiness Standards Committee, which develops transaction and schema standards for EDI and XML is currently working on an EDI 816-equivalent schema for XML, and expects to complete it before the next HIBCC board meeting in August. Refer to the minutes from the eBusiness Standards Committee for additional information.

**Pre-certified HIN Requests**

Pre-certified HIN requests are verified HIN submissions from subscribers. Submission of verified HIN requests would avoid HIBCC verification procedures, potentially resulting in faster turnaround and a reduced cancellation rate. It may also be an integral part of iHIN hierarchy construction and maintenance procedures. However, there are several issues that need to be addressed, particularly those related to verification consistency. Currently, HIBCC is the sole verifier of HIN requests, meaning that a single verification and data content standard is applied to all HIN records. Distributing verification responsibilities to subscribers potentially opens the HIN database to hundreds of verification and data content standards, which could degrade the quality of the data. Another issue is associated with the data templates used for submitting HIN requests. The EDI 816 transaction set uses the ASI02 data element to indicate whether or not a HIN request has been verified (008 for verified, 009 for not verified), but there is no available field in HIBCC's text file template used to transmit HIN requests. Therefore, system changes will be required if HIBCC decides to accept pre-verified HIN requests from human health subscribers. (Pre-certified HIN requests are already transmitted from the AHJ EDI Special Project.)

Last year, HIBCC proposed a pilot to understand and resolve the issues surrounding pre-certified HIN requests, with Baxter as the test subscriber. The test protocol is relatively straight-forward. Pre-certified HIN requests will be submitted to HIBCC via EDI. HIBCC will re-verify the requests during processing and will then conduct an analysis of discrepancies. Any verification or data content differences will be discussed with Baxter, and a retest may be performed if significant issues persist. HIBCC will then make its recommendations to the HIN User Group.

During the discussion, HUG participants raised several issues relating to how HIBCC would track verification sources on HIN records. Currently, verification is indicated only by a verified/not verified indicator (VF/NV), where verification means that HIBCC verified the entity through direct telephone contact. Users indicated that more information would be required in a pre-certified HIN request

environment, although there was no agreement whether the identity of the submitter should be retained or whether a flag indicating the verification was pre-certified should be used. The group did not discuss the issue in greater detail other than to express their interest and desire to discuss the issue in more depth at the next HUG meeting, when results from the pilot are expected to be known. HIBCC suggested convening a sub-committee to address the issues, which was accepted by the group.

HIBCC is ready to start the pilot, but Baxter has requested a delay until key resources are available. HIBCC expects the pilot will be completed before the next HUG meeting.

### **National Provider Identifier**

The federal government issued a final rule on the National Provider Identifier (NPI) on January 23, 2004. Below is a summary distilled from the Federal Register, where the final rule was posted.

- Effective date of the final rule is May 23, 2005.
- Covered entities must use the identifier in standard transactions no later than May 23, 2007. Small health plans must do so no later than May 23, 2008.

Covered entities are health plans, health care clearinghouses, and health care providers that transmit any health information in electronic form for which the Secretary of Health and Human Services has adopted a standard. Furthermore, all health care providers are eligible to receive NPIs. *Entities that do not furnish health care, and do not meet the definition of health care provider will not be eligible to receive NPIs.* [This could exclude a significant proportion of customers or end-users in the health care supply chain.] A covered health care provider will be required to disclose its NPI, when requested, to any entity that needs the NPI to identify that health care provider in a standard transaction.

- The NPS will ensure the uniqueness of the NPI by assigning only one NPI to a health care provider with a distinct string of data in the NPS.

The NPS will capture the mailing address and one physical location address for each health care provider. Only one physical location address will be associated with each NPI, and *health care providers will not be enumerated at multiple locations.* The NPS will not establish location codes for alternate practice locations of providers or multiple ship-to, bill-to locations within corporate entities. *The NPS will not support linkage among NPIs,* e.g. linking health care providers to a group.

- A single entity, under HHS direction, will handle the enumeration functions.

The enumeration function and the development and operation of the NPS will be federally funded. *Health care providers must submit applications for NPIs to HHS. The NPS will verify the SSN only.* Once an NPI is assigned, the health care provider will be notified of its NPI. *The health care provider will be responsible for notifying interested parties of its NPI.* Health care providers will be responsible for notifying the NPS of changes in their required NPS data. *Only covered entities will be required to update their data.* Covered entities will be required to notify the NPS of changes in their required NPS data within 30 calendar days of the changes. *HHS expects that the update process will be designed to allow the system to process updates within a reasonable time frame (10 business days) of receipt.* (If a health care provider does not furnish a social security number when applying for an NPI, the assignment of an NPI to that health care provider may be delayed and additional information may be requested from the provider to establish uniqueness.) A new NPI will not be required for change of ownership, change from partnership to corporation, or change in the State where an organization is incorporated. *A new NPI will not be required with there is a change in an organization health care provider's name, EIN, address, taxonomy classification, state of licensure or state license number. If a previously deactivated organization health care provider is later reactivated, its previous NPI will be reactivated.*

- Data dissemination is not part of the final rule

HHS expects to make routinely available, via the Internet and on paper, HHS-formatted data sets that will contain general identifying information, including the NPI, of enumerated organization health care providers. However, *the data dissemination strategy and the process by which it will be carried out will be described in detail at a later date and published in a notice in the Federal Register.*

### **Class of Trade “Contamination” in the HIN Database**

A handful of subscribers have noted that PHS covered entity codes are in the human health facilities file, and human health activity codes (for locations) are in the PHS covered entity file. HIBCC used the issue to give a broad overview of how the HIN database is divided and why the problem occurs.

The HIN database is divided into two supersets, facilities and prescribers. Facilities are establishments or other types of business units, while prescribers are individuals. The HIN database is also divided into seven subsets:

- Human health facilities,
- PHS covered entities,
- Animal health facilities,
- Veterinarians,
- Medical doctors,
- Dentists,
- Producers (proprietary to the AHI EDI Special Project)

All HIN entities are assigned a “class of trade” code, which are either *market segments* or *activity codes*. Market segments are industry classifications applied to HIN facilities, and medical credentials when applied to prescribers. Activity codes are associated with HIN locations and represent service codes when applied to physical locations of facilities, and program types when associated with PHS covered entities.

Superset, subset and class of trade assignment are governed by several HIN rules. First, membership of a HIN in a superset is mutually exclusive. A HIN can be associated with a facility or a prescriber, but not both. Second, subsets are affiliated with supersets. Human health facilities (and locations), animal health facilities (and locations), producers, and PHS covered entities are all associated with the facilities superset. Medical doctors, dentists and veterinarians comprise the prescriber superset. Third, subset membership is non-exclusive. In other words, a HIN can be associated with more than one subset, subject to the above constraints. Fourth, membership in a subset cannot be revoked, i.e. once a member, always a member. Fifth, a HIN can be associated with one and only one class of trade or activity code.

In general, activity codes for locations should conform to subset, i.e. PHS covered entity codes should be for the PHS subset only, while other location codes apply to human and animal health physical locations. HIN software enforces this constraint when HINs are added to the database. However, occasionally operator error introduces a PHS covered entity into the human health subset or introduces a human health location into the PHS subset during record creation. This error can be corrected, but once an entity has been added to a subset, it cannot be removed. Therefore, there are some human health locations in the PHS subset and some PHS entities in the human health subset.

There are two strategies for dealing with this, acceptance or rejection. Acceptance means ignoring class of trade exceptions and loading the HIN record. Rejection is the opposite action. HIBCC advises accepting the exceptions, even though the HIN records do not belong in the subset. Either strategy is acceptable. Users should remember that class of trade assignment is advisory rather than definitive and is included primarily to provide cross-referencing information.

### **Other Business**

Doug Clark of Merck Vaccine Division suggested that the HIN Implementation Guide should be updated with information such as class of trade exception processing. As Merck is in the midst of a HIN

implementation, he volunteered to form a HUG sub-committee to undertake such an effort. HIBCC will send the most recent implementation guide (circa 1998?) to Doug for review.

HIBCC received two enhancement requests for iHIN. One would allow a user to enter a wildcard character into the HIN search field to return one or HINs. Another user asked if the application could be modified to allow entering more than one HIN into the search field, essentially “joining” a list of HINs to the HIN database. HIBCC will assess these requests and respond at the next HUG meeting.

Following final remarks, the meeting concluded at 11:30 am.