**User Story Number:** US2543

**User Story Name:** Medicare Beneficiary Identifier (MBI) Request

**Author:** eInsurance

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| **Epic Taxonomy** | eBiz Compliance  Port  Update  Increase No Touch  TAS Apps |

# Story

As an Insurance Verification user, I need to generate an ad hoc (real-time) message for a patient who may have Medicare coverage to request the patient's new Medicare Beneficiary Identifier (MBI) number so I can load that value in the patient's Medicare insurance file.

**\*\*\*Note\*\*\***

*This is VA special access granted by the Centers for Medicare Services (CMS). Neither the existence of this ability nor the details of this process shall be shared outside this team. Sharing these details outside of eBusiness Solutions, the assigned Development team(s), VA Financial Services Center (FSC), and VA Office of Information and Technology (OIT) would compromise the VA ability to exchange this transaction with CMS. VA eBusiness Solutions is the only entity being offered this special access.*

# Problem Statement

The Centers for Medicare & Medicaid Services (CMS) is replacing their Health Insurance Claim Number (HICN or HIC) with a Medicare Beneficiary Identifier (MBI). The MBI shall become the identifier that eInsurance routines store as Subscriber ID for Medicare subscribers (in place of the HICN).

# Related Documents

* *US2543 – Medicare Beneficiary Identifier (MBI) Request – Developer Considerations*
* *US2644 – Capture REF Q4 Content in Medicare EIV and MBI Responses* (Future)
* *US2646 – Ad Hoc Medicare Beneficiary Identifier (MBI) Cleanup Extract* (Future)
* *eBilling User Story 2556 – Remove All Checks for Valid HIC Format* (Dependency on this user story)

# Background

CMS plans a phased transition to the use of the MBI. The date boundaries for the transition period are below:

* Begin **April 1, 2018**
* End **December 31, 2019**

CMS will begin mailing new cards (bearing the MBI) to their subscribers in a phased mail-out, beginning **April 1, 2018**. The CMS scheduled “go live” for the MBI Request transaction being offered to VA is **March 10, 2018**. During the HICN-to-MBI transition period, CMS will accept either the HICN or the MBI as the Subscriber ID in incoming transactions, with the following exception:

* Patients who are newly enrolled in Medicare (with effective dates **of April 1, 2018**, or later) will not be issued a HICN. Any transactions submitted on behalf of these patients after April 1, 2018, must submit the MBI as Subscriber ID for that patient (with no exceptions).

As of **January 1, 2020**, all Medicare transactions sent to CMS must include the MBI. Any transaction with a HICN would thereafter be rejected for the reason *Invalid Subscriber ID*.

**User Story Scope**

The scope of this user story includes interdependent effort in three functional areas:

* Development of **MB MBI Request** action from EIV > EI (Request Electronic Insurance Inquiry)
* HL7 Administration message standard implications
* FSC (EDI 270/271) processing implications

# MBI Request Menu and Prompt Sequences

It is proposed that the existing EIV menu and EI (Request Electronic Insurance Inquiry) function be used to implement the proposed MB MBI Request action.

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Select Patient Insurance Menu <TEST ACCOUNT> Option: EIV eIV Menu

AB Add Auto Match Entries Using Insurance Buffer Data

AE Enter/Edit Auto Match Entries

EI Request Electronic Insurance Inquiry

HL HL7 Response Report

IU eIV Auto Update Report

LR eIV Payer Link Report

MW Medicare Potential COB Worklist

NI Potential New Insurance Found

PR eIV Payer Report

RR eIV Response Report

SR eIV Statistical Report

Select eIV Menu Option: EI Request Electronic Insurance Inquiry

Select PATIENT NAME: <ENTER PATIENT NAME>

**eIV Insurance Request** Aug 01, 2017@18:49:18 Page: 1 of 1

Request Electronic Insurance Inquiry for Patient: IB,PATIENT IXXXX

\*\*\* Patient has Insurance Buffer Records

Insurance Co. Type of Policy Group Holder Effect. Expires

1 MEDICARE (WNR) MEDICARE (M) PART A SELF 06/22/2017

2 MEDICARE (WNR) MEDICARE (M) PART UNKNOWN

Enter ?? for more actions

SE Select Entry MB – MBI Request EX Exit

Select Action: Quit// **MB**

Are you sure you want to request this Patient’s Medicare Beneficiary Number? YES// **Y**

Insurance Buffer entry created!

Type <Enter> to continue or '^' to exit:

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# MBI Request Business Rules

* MBI Request (MB) action shall be initiated from the EIV EI menu (and no other menu action shall trigger MBI Request).
* MBI Request (MB) action shall be signified on the **EIV EI** display as **MB – MBI REQUEST**.
* MBI Request (MB) action shall generate a real-time transaction which begins as an entry in the Insurance Verification Processor (*Buffer*) File (#355.33) and is subsequently transferred to the IIV Transmission Queue (#365.1) in the same way as the current EI Request Electronic Insurance Inquiry.
* MBI Request (MB) action shall make inquiry using the following data elements (which shall be derived from the Patient context and shall not be prompted entries in the MB action):

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Element** | **HL7 Segment/Sequence** | **X12 270 Segment/Designator/Loop** | **Comments** |
| Patient Last Name | PID/5-1-1 (Last Name) | NM1 NM103 Loop 2100C (all) | Populate using current process. |
| Patient First name | PID/5-2 (First name) | NM1 NM104 | Populate using current process. |
| Patient DOB | PID/7-1 (Date) | DMG DMG02 | Populate using current process. |
| Patient Social Security Number | PID/19 (SSN) | NM1 NM109 | “Reactivate” HL7 segment and populate with SSN. |

* VistA shall map the Patient Name and Date of Birth as sent in the MBI Request to *Buffer* file.
* MBI Request (MB) action shall assign the *Special MBI Payer*[[1]](#footnote-1),[[2]](#footnote-2) as defined in the IB Site Parameters File to the MBI Request and shall display the value assigned to that parameter (defined as “CMS MBI ONLY”) in the Insurance Company field of the *Buffer* display.
* For MBI Request (MB), VistA shall populate the Subscriber ID field in the *Buffer* file and display with the value “MBIrequest[[3]](#footnote-3)
* MBI Request (MB) action shall populate the (existing) **second** repeating NTE segment of the HL7 message, which is designated as *Source of Information* (SOI), with the value “MEDICARE.”
* MBI Request (MB) action shall include a *Type of Request* identifier of “MBI” in a proposed **third** repeating NTE[[4]](#footnote-4) segment of the HL7 message.
* When processing the MBI Request, VistA shall automatically set Patient Relationship to Insured = *Self*.

# MBI Response Business Rules

* VistA shall map the MBI number received in the HL7 Response (IN1 Segment, Sequence 2-1) to the Subscriber ID field in the *Buffer* file.
  + VistA shall map the Payer name received in the HL7 Response to the Insurance Company field in the *Buffer* File.
* When processing the MBI Response, VistA shall automatically set Patient Relationship to Insured = *Self*.
* The Response received as a result of the MBI Request (even when successful) shall not auto-update in the IIV Response File (#365).
* The Response received as a result of the MBI Request shall be persisted in the *Buffer* and shall remain there until processed by a human.
* If CMS is able to locate the Patient who is the subject of an MBI Request, but the new Identification Card (with MBI) has not yet been mailed to that patient, when CMS/FSC returns the message *New Medicare Card with MBI Not Yet Mailed* (as detailed in the Business Rule below) that message shall be displayed in the VistA (and ICB) *Buffer* entry (as static information for the user).

# FSC Business Rules/Requirements

# *FSC-specific Business Rules are stated here to ensure end-to-end coverage of the proposed functionality.*

* For the MBI Request X12 270 transaction, FSC shall populate the Patient Name, Patient DOB, and Subscriber ID (Patient SSN shall be sent in the segment for Subscriber ID, MM109).
* The MBI Request X12 270 transaction conveyed to CMS shall supply the following data elements for the transaction (in addition to those populated by VistA in the HL7 message as articulated above):
  + **Station NPI**[[5]](#footnote-5) (FSC shall populate this field).
  + A **Submitter ID** that is unique to the MBI Request action and is different from the Submitter ID used for Insurance Verification requests sent to CMS (FSC shall populate this field).
  + **Subscriber ID Code Qualifier = “MI”** (FSC shall populate this field in the X12 270 as is currently done for the Insurance Verification Request).

**CMS Not Able To Locate Patient**

* + If CMS is unable to locate the Patient who is the subject of an MBI Request and responds with an AAA\* Request Validation error of *Invalid Subscriber ID*, then FSC shall echo back the Patient Identification (PID) and Payer ID (IN1) that were sent by VistA (FSC shall use existing mapping to echo).

**CMS Able to Locate Patient but Identification Card with MBI Has Not Yet Been Mailed**

* + If CMS is able to locate the Patient who is the subject of an MBI Request but the new Identification Card (with MBI) has not yet been mailed to that patient, and CMS responds with the message *New Medicare Card with MBI Not Yet Mailed*, then FSC shall to use existing mapping to echo back the data that was sent by VistA.
* When CMS returns the message *New Medicare Card with MBI Not Yet Mailed*, FSC shall convey that message text to VistA (and also make it available to ICB) for display in the *Buffer* entry.

**FSC Definition and Communication of Special MBI Payer**

* + FSC shall define a *Special MBI Payer* and shall control the value assigned to that Special Payer using a site parameter.
    - FSC shall send a *Payer Table Update Message* (File #365.12) to all sites to create the Special MBI Payer (Payer ID = VA National ID).
    - FSC shall send a *Table Update Message–IB Site Parameters* (File #350.9) to the sites to convey the value (pointer) for the *Special MBI Payer*.

# CMS Test Interval and Test Alternatives

CMS will be testing in *live production* during the period beginning **January 29, 2018**, and ending **February 23, 2018**. This window of opportunity for VA to test live with CMS coincides with the currently scheduled IOC timeframe for eInsurance **Build 4** (January 16 to February 13, 2018).

In the event that dependencies and/or constraints do not allow readiness to test during this window, FSC has proposed a backup plan to test using a simulated environment.

# Test Considerations

* + There is some Build 4 *gatekeeper[[6]](#footnote-6)* code with restrictive criteria for the throughput of test patients to the FSC Eligibility Communicator (IBCNEUT7 – *General eIV Utilities*) which should not be supplied to sites during IOC (due to the potential for creating extra work for testers). Suggestion is to test this functionality during the Component Integration Test (CIT) and/or User Acceptance Test (UAT).
  + The EI Request Electronic Insurance Inquiry function has a security key (IBCNE IIV SUPERVISOR) assigned at the menu level; however, it has been verified that CPAC assigns that key to all users. A future user story is proposed to remove this security key, since it has no effect.
* To assist in the identification of the MBI Request/Response and its association with the designated *Special Payer* (pursuant to the proposal to use a unique Payer both for the MBI Request and also for the future Insurance Discovery Extract Request[[7]](#footnote-7)), the user should set Auto Match [site parameter *X (*instead of “CMS”)] to [site parameter *Y* (the site parameter for the *Special MBI Payer*, instead of “Medicare Payer”)].
* Vista must be able to handle the condition where the site parameter for *Special MBI Payer* has not yet been populated (due to the possible non-sequential receipt of Table Update Messages for the Payer Table and the associated site parameter).

The following FSC-specific functionality (cited in the Business Rules section of this User Story) must be tested with ICB as well as in the VistA user interface:

* When CMS returns the message *New Medicare Card with MBI Not Yet Mailed*, then FSC shall convey that message text to VistA (and also make it available to ICB) for display in the *Buffer* entry (as static explanatory information for the user).

# Assumptions

* It is assumed that, although the current code for EI Electronic Insurance Inquiry (Routine IBCNEQU) blocks inquiries for non-Veterans/dependents, that block will not adversely impact the outcome for MBI Requests (spouses and/or dependents would typically be covered by Tri-Care or CHAMPVA).
* VistA will not transmit the GT1 (Guarantor) segment in the HL7 message for the MBI Request, because patient relationship to insured will always be *Self*.

# Acceptance Criteria

| Requirement ID | Description | External Dependency\* (Y/N) |
| --- | --- | --- |
| **Acceptance Criteria: MBI Request** | | |
| 1.0 | MBI Request (MB) action, designated MB, is selectable from the EIV EI menu and no other menu. | N |
| 2.0 | MBI Request (MB) action generates a real-time transaction which begins as an entry in the Buffer file and is subsequently transferred to the Transmission Queue, in the same way as EI Request Electronic Insurance Inquiry. | N |
| 3.0 | MBI Request (MB) action makes inquiry using the following data elements, all of which are derived from the Patient Context and none of which are prompted entries in the MB action:  Patient Last Name Patient First Name Patient DOB Patient Social Security Number | Y – Potential need for HL7 Administration Approval to Reactivate PID19 for SSN. |
| 4.0 | VistA maps the Patient Name and Date of Birth as sent in the MBI Request (and received in the MBI Response) to the *Buffer* file. | N |
| 5.0 | MBI Request (MB) action assigns the Special MBI Payer, as defined in the IB Site Parameters File, to the MBI Request and displays the value assigned to that parameter in the Insurance Company field of the *Buffer* display. | Y – FSC to create Special MBI Payer |
| 6.0 | For MBI Request (MB), VistA shall populate the Subscriber ID field in the Buffer display with the value “MBIrequest.” | N |
| 7.0 | MBI Request (MB) action populates the existing second repeating NTE segment of the HL7 message, which conveys *Source of Information*, with the value “MEDICARE.” | N |
| 8.0 | MBI Request (MB) action populates the third repeating NTE segment of the HL7 message, which is designated to convey *Type of Request*, with the value “MBI.” | Y – HL7 Administration Approval |
| 9.0 | When processing the MBI Request, VistA automatically sets Patient Relationship to Insured = “Self.” | N |
| **Acceptance Criteria: MBI Response** | | |
| 10.0 | VistA maps the MBI number received in the IN1 segment of the HL7 Response to the Subscriber ID field in the *Buffer* file. | N |
| 11.0 | VistA maps the Payer name received in the HL7 Response to the Insurance Company field in the *Buffer* file. | N |
| 12.0 | When processing the MBI Response, VistA automatically sets Patient Relationship to Insured = “Self.” | N |
| 13.0 | The Response received as a result of the MBI Request (even when successful) does not auto-update in the IIV Response File (#365). | N |
| 14.0 | The Response received as a result of the MBI Request is persisted in the Buffer and remains there until processed by a human. | N |
| 15.0 | If CMS/FSC returns the message *New Medicare Card with MBI Not Yet Mailed,* thenVistA displays that message in the Buffer entry. | Y – FSC returns message text |
| \*Any dependencies identified in this column are correlated with the dependency descriptions supplied in the section that follows. | | |

| Requirement ID | Description | External Dependency (Y/N) |
| --- | --- | --- |
| **Acceptance Criteria: FSC Functionality** | | |
| *Acceptance Criteria pertaining to FSC functionality are stated here to ensure full coverage of all relevant test/acceptance criteria.* | | |
| 16.0 | FSC populates the X12 270 with Patient Name, Patient DOB, and Subscriber ID (Patient SSN is sent in the segment for Subscriber ID, NM109). | N |
| 17.0 | FSC populates the X12 270 Request with the Station NPI for the site originating the transaction. | N |
| 18.0 | FSC populates the X12 270 Request with a Submitter ID unique to the MBI Request (and different from the Submitter ID used for an eIV Request). | N |
| 19.0 | FSC populates the X12 270 Request (NM108) with the Subscriber ID Code Qualifier “MI,” in the same way that this ID Code Qualifier is mapped for an eIV Request. | N |
| 20.0 | If CMS is unable to locate the Patient who is the subject of an MBI Request and responds with an AAA\*Request Validation error of *Invalid* *Subscriber ID*, then FSC uses existing mapping to echo back the Patient Identification (PID) and Payer ID (IN1) that were sent by VistA. | N |
| 21.0 | If CMS is able to locate the Patient who is the subject of an MBI Request but the new Identification Card (with MBI) has not yet been mailed to that patient, and CMS responds with the message *New Medicare Card with MBI Not Yet Mailed,* then FSC uses existing mapping to echo back the data that was sent by VistA. | N |
| 20.1 | When CMS returns the message *New Medicare Card with MBI Not Yet Mailed,* then FSC conveys that message to VistA (and also to ICB) for display in the *Buffer* entry. | N |

# Dependencies

# Dependencies on HL7 Administration Approval

The eInsurance Build 4 Patch includes HL7 message changes that are presently in the HL7 approval process. It is proposed that any additional modifications associated with the MBI Request be included in the current approval process (email notice sent to HL7 Administration 8/25/2017, and conditional approval received 8/29/2017).

* HL7 approval is required for the use of a third repeating NTE segment in the HL7 message to convey a *Type of Request* indicator (with a value of “MBI” for an MBI Request).
* HL7 approval may be required to reactivate PID segment (sequence 19) and populate that segment with the Patient SSN.
* HL7 approval is required to change the *Table Update Message (Non Payer)* to update the site parameters with the value assigned to the *Special MBI Payer*.

# Dependencies on FSC (repetition of Business Rules stated above)

* For the MBI Request X12 270 transaction, FSC shall populate the Patient Name, Patient DOB, and Subscriber ID (Patient SSN shall be sent in the segment for Subscriber ID, MM109).
* The MBI Request X12 270 transaction conveyed to CMS shall supply the following data elements for the transaction (in addition to those populated by VistA in the HL7 message as articulated above):
  + **Station NPI**[[8]](#footnote-8) (FSC shall populate this field).
  + A **Submitter ID** that is unique to the MBI Request action and is different from the Submitter ID used for Insurance Verification requests sent to CMS (FSC shall populate this field).
  + **Subscriber ID Code Qualifier = “MI”** (FSC shall populate this field in the X12 270 as is currently done for the Insurance Verification Request).

**CMS Not Able To Locate Patient**

* + If CMS is unable to locate the Patient who is the subject of an MBI Request and responds with an AAA\* Request Validation error of *Invalid Subscriber ID*, then FSC shall echo back the Patient Identification (PID) and Payer ID (IN1) that were sent by VistA (FSC shall use existing mapping to echo).

**CMS Able to Locate Patient but Identification Card with MBI Has Not Yet Been Mailed**

* + If CMS is able to locate the Patient who is the subject of an MBI Request but the new Identification Card (with MBI) has not yet been mailed to that patient, and CMS responds with a the message *New Medicare Card with MBI Not Yet Mailed*, then FSC shall to use existing mapping to echo back the data that was sent by VistA.
* When CMS returns the message *New Medicare Card with MBI Not Yet Mailed*, FSC shall convey that message text to VistA (and also make it available to ICB) for display in the *Buffer* entry.

**FSC Definition and Communication of Special MBI Payer**

* + FSC shall define a *Special MBI Payer* and shall control the value assigned to that Special Payer using a site parameter.
    - FSC shall send a *Payer Table Update Message* (Payer File #365.12) to create the Special MBI Payer for the sites (Payer ID = VA National ID).
    - FSC shall send a *Table Update Message (Not Payer)* to convey the value for a new *Special MBI Payer* site parameter to the sites.

# Dependency of eBilling User Story on US2543 MBI Request

* eBilling *US2556 – Remove All Checks for Valid HIC Format* is dependent on the completion and installation of the system changes described in this user story.

# Related Future User Stories

At least three future User Stories pertaining to the functionality specified or implied here exist in draft form:

*US2644 – Capture REF Q4 Content in Medicare EIV and MBI Responses*

The modifications specified in this user story would allow FSC to process rather than dismiss the data conveyed in the REF Q4 segment (when returned with a AAA) error and pass that information to VistA for persistence and possible subsequent processing.

* + When an EIV Request is sent to CMS for a subscriber who is deceased, CMS may return the Subscriber ID for that person’s qualifying dependent in 2100C/NM109 and the old ID, as submitted, in a REF\*Q4 segment.
  + When an EIV Request sent to CMS supplies the HICN (as Subscriber ID) and an MBI has been provided to that subscriber, then CMS will return an MSG segment indicating MBI has been assigned/new card has been mailed along with the normal response (CNS will not return the new MBI in this scenario).

*US2646 – Ad Hoc Medicare Beneficiary Identifier (MBI) Cleanup Extract*

The functionality to be specified in this user story is dependent on the future existence of a CMS-supplied *crosswalk* table or spreadsheet containing assigned MBI numbers. This user story would create a VistA extract that could be triggered by FSC. This *cleanup* extract would assist with populating the MBI in the Subscriber ID field for patients with known Medicare policies that currently contain a HICN – so that insurance verification staff members do not have to manually enter the MBI in the database.

*US[#TBD] – Automatically Trigger Standard EIV Request after Successful MBI and/or Insurance Coverage Discovery Response*

The feasibility of this potential future user story is currently being evaluated.

# Constraints

None identified.

# Summary of Key Dates

|  |  |
| --- | --- |
| **Event** | **Date** |
| eInsurance Build 4 IOC Test Period (current schedule) | **January 16 to February 13, 2018** |
| CMS Offering VA Test in Live Production Environment | **January 29 to February 23, 2018** |
| **Overlap** of Build 4 IOC and CMS Live Production Test Availability | **January 29 to February 13, 2018** |
| CMS “Go Live” with MBI Request Transaction being offered to VA | **March 10, 2018** |
| CMS Begins Transition to MBI | **April 1, 2018** |
| CMS First of Several Mailings of New Cards (Bearing MBI) to Subscribers | **April 1, 2018** |
| CMS Will Accept either HICN or MBI in Insurance Verification Requests | **April 2, 2018 to December 31, 2018** |
| CMS Concludes Transition to MBI | **December 31, 2019** |
| All Medicare transactions sent to CMS must include the MBI to avoid rejection for the reason *Invalid Subscriber ID* | **January 1, 2020** |

# Risks & Benefits

No specific risks – other than dependence on the timing of the CMS test interval in order to test without creating a simulated environment – have been identified.

# Approval Signatures

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# Revision History

| Date | Version | Description | Author |
| --- | --- | --- | --- |
| 9/14/2017 | 0.5 | Updates after all open issues addressed in USD&P. Added requirement to populate Submitter ID in Request with filler (MBIrequest) to leverage existing real time transaction processing functionality. Submitted to eInsurance and Development Teams for final review before submitting for eBusiness and OIT approval. | R. Russell |
| 9/11/2017 | 0.4 | Modifications after Developer Review with Tim Zimmer and Henry Normand. Removed references to non-HL7 data elements. Clarified that this *real-time* transaction does not enter the Buffer queue; instead, it goes directly to the Transmission Queue and out (to FSC). Completed articulation of Acceptance Criteria (to correspond to Business Rules). | R. Russell |
| 9/4/2017 | 0.3 | Modifications to reflect the most current design decision for conveying information in repeating NTE segments of the HL7 message. | R. Russell |
| 8/30/17 | 0.2 | Incorporated suggestions from first USD&P and posed additional questions in sidebar comments. | R. Russell |
| 08/28/17 | 0.1 | Draft for eInsurance Team and Developer Review | R. Russell |

1. Medicare Payer in IB Site Parameters is currently defined as the Medicare entry from the Payer file (#365.12). It is used to identify the Medicare payer for the insurance buffer lists and any other applications that need to know which payer is the Medicare WNR Payer. [↑](#footnote-ref-1)
2. It is proposed that a *unique special Payer* be defined by FSC for the MBI Inquiry, which shall be different from the CMS/Medicare Payer. It is anticipated that in the future a similar *unique special Payer* will be defined for the vendor supporting Insurance Coverage Discovery Extract (US2541), to assist in uniquely identifying these special request types. [↑](#footnote-ref-2)
3. Populating the Subscriber ID is required in order to leverage the existing “real time” processing functionality that allows a Request to leave the *Buffer* and move to the Transmission Queue. Because a Subscriber ID is not part of the specified dataset to be sent to CMS, VistA will populate that field with the human-readable indicator “MBIrequest.” [↑](#footnote-ref-3)
4. The first occurrence of the NTE segment is used for STC, Service Type Code = 30). The second occurrence of the NTE segment is used for SOI, Source of Information (Medicare). A future user story may propose a fourth NTE segment which would convey a *Type of Transmission* indicator of either “Real-Time” or “Night/Batch.” [↑](#footnote-ref-4)
5. National Provider Identifier – A unique 10-digit number issued by CMS to healthcare providers in the United States, including VA Medical Centers. *Stations* are VA accounting classification units. [↑](#footnote-ref-5)
6. In order to test the eIV interface from a development/test account with the test Eligibility Communicator (EC), the developer must use a small set of pre-approved test patients with specific criteria that the Financial Services Center (FSC) has agreed upon. The criteria are presented in Appendix F of the *eIV Technical Manual*. [↑](#footnote-ref-6)
7. US2541 [↑](#footnote-ref-7)
8. National Provider Identifier – A unique 10-digit number issued by CMS to healthcare providers in the United States, including VA Medical Centers. *Stations* are VA accounting classification units. [↑](#footnote-ref-8)