**CMS - Medicaid Provider Screening Portal - Provider Business Rules - Part 1 1.0 Requirements Specification**

***This document outlines the Application Scope and Requirements for   
CMS - Medicaid Provider Screening Portal - Provider Business Rules - Part 1 1.0.***

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# Application Requirements Specification

# Scope

## Overview

The client for this project is the Minnesota Department of Human Services (MN-DHS). The MN-DHS compensates medical service providers through a healthcare program called Medicaid.  Medicaid is funded by the United States government, and it is operated by individual states (including the MN-DHS). Medicaid provides health benefits to more than 60 million Americans which include children, parents, senior citizens, pregnant women and disabled people.

New regulations (effective March 25, 2011) require all newly enrolling health care providers who participate through Medicare, Medicaid and CHIP to complete a "Risk-Based Provider Screening" process. Providers who are currently enrolled must be re-enrolled at least once every five years, and they must also go through the “Risk-Based Provider Screening” process as well.

MN-DHS's current Provider Enrollment systems must be modernized in order to meet the demands of these new federal regulations. They estimate around 44,000 provider enrollment screenings will be required annually, and their current staff and systems cannot process this high volume of screenings as it is.

To solve this problem and process provider enrollment and renewals in compliance with the new Provider Screening Regulations, a large IT project has been launched to build a system called the Medicaid Provider Screening and Enrollment (MPSE). Several key components have been identified for the overall MPSE project:

1. A front-end Provider Enrollment Processor (PEP),
2. A back-end Provider Validation Service (PVS), and
3. Related MMIS System and Associated Database changes (the current MN-DHS system)

For this particular piece of the project, only the Provider Enrollment Processor (PEP) component is in scope.

The front-end PEP application is responsible for collecting required provider based data and scanned images (medical certificates and licenses). It also has the ability to collect payment (if applicable) and to send collected data to external systems, such as the SIRS Site Visit and NetStudy background check systems. Additionally, it will send and receive data from both the back-end PVS system and the existing MMIS system (both out of scope for this piece of the project).

The front-end Provider Enrollment Processor (PEP) system will utilize a dynamic set of business rules to collect the appropriate needed information and direct the enrollee to the various areas of the application to be completed based on preset parameters, such as provider type or level of assigned risk (Limited, Moderate, or High).

Essentially, the PEP serves as the starting point for all new applicants seeking to enroll and for existing providers seeking re-enrollment. It also applies to any provider when a change to their data may trigger additional screening or follow-on actions (e.g., a change of ownership). It serves as both the brains and the gatekeeper for all downstream processing as data collected in this stage determines what has to take place at the various junctures to comply with the screening regulations.

A previous TopCoder Conceptualization contest (“Medicaid Provider Screening Portal Application Conceptualization 1.0”) has been completed to define the basic system design of the PEP application. This contest will serve as supporting documentation for that existing conceptualization document, and will dig deeper into the details around the business rules necessary for the PEP application.

The business rules for the provider enrollment and screening process is an important piece of the project. The PEP will assign a potential level of risk to each registrant, and will do this by applying a suite of dynamic business rules. Once a level of risk has been assigned, the registrant's application will be sent to the appropriate sub-system for additional screening and processing.

This specification contest takes the screening rules conceptualization documents and wireframes and distills the business rules to form a professional Business Rules Document that can be later used for Business Rules Management. We will be using [Drools](http://www.jboss.org/drools) for writing the rules.

Only the following provider types needs to be covered.

* Audiologist
* Certified Professional Midwife
* Community Health Care Worker
* Clinical Nurse Specialist
* Certified Registered Nurse Anesthetist
* Chiropractor
* Podiatrist
* Licensed Marriage and Family Therapist
* Licensed Psychologist
* Licensed Professional Clinical Counselor
* Physician
* Nurse Practitioner
* Occupational Therapist

## Objectives

The objectives of the entire CMS Medicaid Provider Screening Portal application are as following of that main application).

Must have:

* To design a set of screening rules and workflows to expand on the enrollment component of the Medicaid Provider Screening Portal Application (system design included in the conceptualization document from the contest “Medicaid Provider Screening Portal Application Conceptualization 1.0”).
* To define a common workflow for collecting enrollment information of individual providers.
* To define the screening/validation rules and workflows for the following Individual Provider Types:
  + Audiologist – Provider Type 43
  + Certified Professional Midwife – Provider Type C1
  + Community Health Care Worker – Provider Type 55
  + Clinical Nurse Specialist – Provider Type 68
  + Certified Registered Nurse Anesthetist – Provider Type 67
  + Chiropractor – Provider Type 37
  + Podiatrist – Provider Type 36
  + Licensed Marriage and Family Therapist – Provider Type 25
  + Licensed Psychologist – Provider Type 42
  + Licensed Professional Clinical Counselor
  + Physician
  + Nurse Practitioner
  + Occupational Therapist
* To support the ability to ask only for relevant information from the user (based on provider type).
* To support the ability to validate provider data against the screening rules for their specific provider type.
* To support the ability to verify licenses and certifications of enrolling providers (automatic verification is the preferred approach by the client).
* To support the ability to upload scanned copies of forms and licenses for verification.
* To support the ability for providers to submit signed forms required for enrollment (required forms determined by their provider type).
* To calculate the risk level of enrolling providers.
* To verify that users are not included on sanctions or exclusion lists
* To have the ability to reject user applications if they are found on sanctions or exclusion lists.
* To send provider data to the PVS and MMIS systems based on the results of screening and enrollment, including results from risk assessment.
* To support the ability to send provider enrollment applications to external systems (such as SIRS System and NetStudy) for additional checks based on calculated risk level.
* To support the ability to validate the NPI number entered by the provider.
* To support the ability to generate a unique identification number (Unique Minnesota Provider Identifier) for the provider if NPI is not entered (and not required).
* To build an application with the ability to send a request to the MN-ITS system to create a mailbox account for the enrolling provider.
* To design an application that complies with Section 508 of the Americans with Disabilities Act requirements.
* To build an application with the ability for users to request help.
* To build an application with the ability to check and see if users exist in the Medicaid Provider Screening Portal system already.

Nice To Have Features:

* The ability to have providers enter their license or certification number and have it automatically verified through the correct organization is a nice to have feature the client would like to have (open issue for architect)

Project Return on Investment (ROI Metrics) are as following:

* None.

General Capacity Metrics:

* At its peak usage, the number of concurrent users should not exceed 100.
* The average number of users on the system at any one time is anticipated to be closer to 25 to 30.

## Limitations & Assumptions

The limitations of this project are listed below:

* This document will only capture the business processes, screening rules and workflows for the selected providers listed above (other providers are captured in separate documents).
* This document will focus on screening rules and workflows, it will not repeat system functionality captured in the previous Medicaid Provider Screening Portal Application conceptualization document.
* The application and business rules for this contest will only cover Individual enrollment. Organization (group) enrollment is out of scope.
* Changes of Ownership (CHOWs) are out of scope for this phase of the project.
* “MAPS” is a system that is no longer used in the enrollment process and is not in scope for this project.
* SharePoint is an internal system the client uses for collaboration. It doesn't interact with the current enrollment system, and is not going to interact with the new system.
* FileNet is the client’s electronic document filing system. It is not used for license or sanctions verification and will not be used in the new system.
* MN-ITS will not factor into provider screening rules (it is only used to create provider mailbox accounts and contains provider details related to billing).
* The purpose of this document is to extend the previous Medicaid Provider Screening Portal Application documentation. It will not be combined with this previous document as part of this contest (previous submission not updated).
* This document focuses on the selected provider types; therefore functionality for other user types of the MPSP application (such as actions performed by service and system users) is not covered here.
* The Medicaid Provider Screening Portal application contains functionality for sending email notifications so this functionality is not captured in this document.
* The MPSP application includes logging and auditing functionality, so the component in this document does not need to.
* The MPSP application includes user login, authentication, and authorization functionality so it is not covered in this component.
* Provider Validation System (PVS) is out of scope for this particular project.
* The MMIS system is not in scope for this project.

Assumptions critical to the success of this project are listed below:

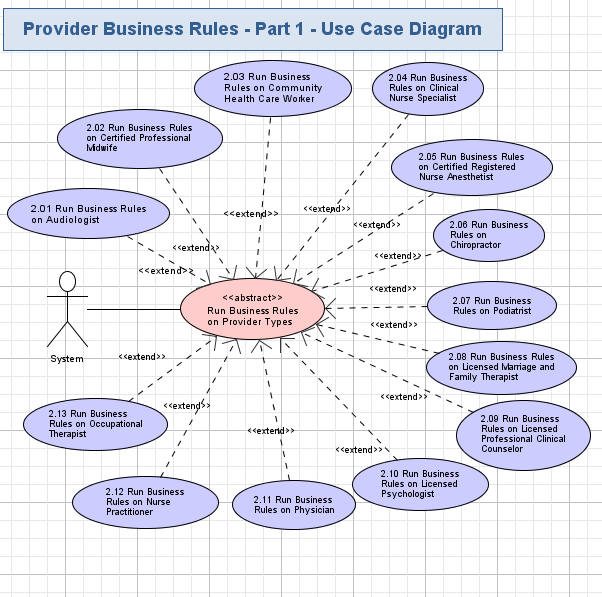
* The business processes, screening rules and workflows defined in this document expand on the conceptualization document from the previous Medicaid Provider Screening Portal Application contest. This document is for a component of the overall system described in that document, so overall system functionality covered in the previous document (like login, logout, auditing, logging, etc.) can be left out of this submission unless a change is needed.
* It is assumed that the reader of this document is familiar with the previous MPSP conceptualization document since this expands upon it.
* Every provider type will have Major Programs (but different combinations).
* Not every provider type will have a Specialty Code.
* Providers only need to agree to Rule 101 when they've decided to limit their patient caseload to 10%-20% (depending on provider type) of Medicaid patients, if they are limiting everyone regardless of insurance, or if they are limiting everyone except children with special health care needs or managed care organization patients.
* The enrollment process is the same as the re-enrollment process (meaning the business logic and screening process is the same for both a new provider enrolling and a current provider re-enrolling).
* All provider types covered in this document have the same access in the application (Service Provider role), although each provider type has a different set of business rules and a different workflow to follow.
* The application will use a combination of provider type and services to determine the risk of some of the Medicaid only providers.
* Not all providers are required to have an NPI. In those cases where it is not required, they are assigned a Unique Minnesota Provider Identifier. This rule will be based on the provider type.
* NPI Type 1 is assigned to individuals. NPI Type 2 is assigned to organizations.
* Provider pre-populated data is only sent to SIRS Site Visit for moderate or high risk providers.
* Background check data is only sent to NetStudy for providers identified as high risk or with 5% or more ownership.
* Background checks (via NetStudy) are required for certain individual provider types (list to be provided).
* Providers found on the sanctions list will be rejected automatically.

**Technical Assumptions:**

* J2EE
* EJB based WS
* Drools
* SOAP
* Oracle 11g

# Logic Requirements

Use case diagram is shown below:



## Run Business Rules on Audiologist

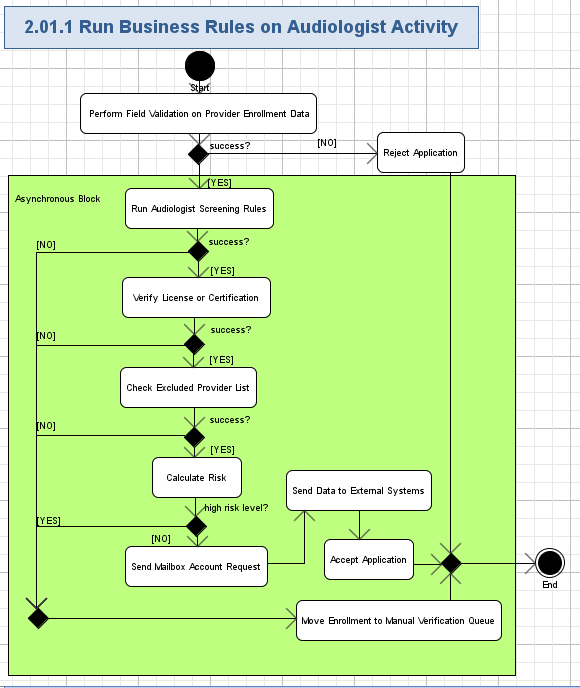
The system will run business rules on the “Audiologist” provider type (the type number is 43). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.2

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Audiologist \_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Audiologist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Audiologist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 43 (Independent Audiologist) |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following programs: BB, FF, IM, JJ, KK, LL, MA, NM, QM, RM, XX, EH, DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following Categories of Service: 043, 053, 058 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "40."  The state is "XX" since ASHA is a national certification.  Skip the VER LTR and BOARD fields.  Also skip restrict and certification verified steps below if pending certification verification.  When verification has been received, enter information.  In the RESTRICT column, enter "A" to indicate an active file.  Enter "Y" to indicate that the certification has been verified. |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Enrollment Criteria** | |
| Independently | Independently enrolled audiologists must maintain an office at their own expense and have a certificate of clinical competence from the ASHA |
| Audiologists | Audiologists who practice in Minnesota must also be registered with the MN Department of Health.  Out-of-state providers must meet the same criteria except for registration with the MN Dept. of Health |
| audiologists and Medicare | Effective January 1, 2009, SLPs, audiologists and Medicare enrolled PTs and OTs are also eligible to enroll with MHCP if they are employed by one of the following group practices:  Federally Qualified Health Center  Indian Health Service  Nursing facility  Outpatient hospital  Physician clinic  Rehabilitative agency  Rural Health Center |
| individual audiologist /hearing aid dispenser | If an individual audiologist or hearing aid dispenser is enrolled and affiliated with one of the identified group practices, be sure to properly affiliate them on the PGRP screen and only put the individual’s SSN on the PADD screen of the provider’s record. The FEIN for the employer should not be listed. |
| **Exceptions** | |
| Audiologist/Hearing Aid Dispensers | A number of audiologists currently enrolled in the Minnesota Health Care Program are additionally qualified as Hearing Aid Dispensers. These individuals are to be enrolled as Independent Audiologists, provider type 43. Both 058 and 077 categories of service are to be added to their provider numbers, and they must include copies of both certificates with their application form. Additionally, their certification numbers as both hearing aid dispensers and audiologists must be entered on the PLIC screen. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Copy of A.S.H.A. Certificate | This certificate is required. |
| Copy of registration with Department of Health | The registration is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.1.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.1.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.1.1.1.

## Run Business Rules on Certified Professional Midwife

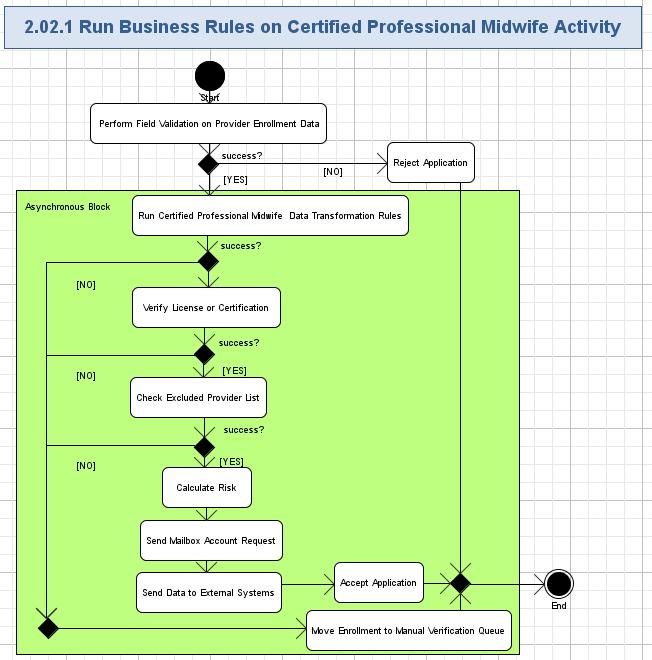
The system will run business rules on the “Certified Professional Midwife” provider type (the type number is C1). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.3

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Certified\_Professional\_Midwife\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Certified Professional Midwife Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Certified Professional Midwife Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = C1 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Status = 3 (Non-pay to) |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following programs: BB FF GM IM JJ KK LL MA NM RM XX EH FP DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following Categories of Service: 032, 043, 080, 090 |
| **PLIC** | |
| License Type | Traditional Midwife = 85  CPM = 66 (Enter XX in State field) |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice.  Reservation:  FL = Fond Du Lac Indian Reservation  GP = Grand Portage Indian Reservation  LL = Leech Lake Indian Reservation  ML = Mille Lacs Indian Reservation  NL = Net Lake Indian Reservation  PI = Prairie Island Indian Reservation  RL = Red Lake Reservation  US = Upper Sioux Indian Reservation  WE = White Earth Indian Reservation  LS = Lower Sioux Indian Reservation |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Traditional Midwife License from the MN Board of Medical Practice | This certificate is required. |
| Professional Midwife Certification from the North American Registry of Midwives | The registration is required. |
| NPI | The NPI is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.2.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.2.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.2.1.1.

## Run Business Rules on Community Health Care Worker

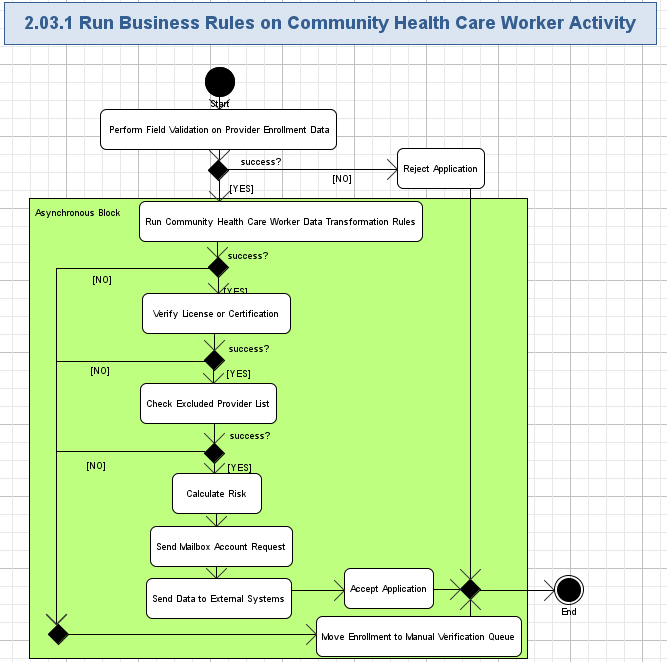
The system will run business rules on the “Community Health Care Worker” provider type (the type number is 55). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.4

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Community\_Health\_Care\_Worker\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Community Health Care Worker Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Community Health Care Worker Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 55 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Status = 3, Non Pay To. CHWs must be employed with an enrolled organization. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following programs: BB EH FF GM IM JJ KK LL MA NM QM RM XX DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following Categories of Service: 043 |
| **PLIC** | |
| license number | School acronym (e.g. MCTC for Minneapolis Community & Tech College) |
| License type | 13 |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Copy of MnSCU certification | This certificate is required.  Copy of MnSCU certification from one of the below approved Colleges or Curriculums:  Summit Academy (gives a certificate)  Inver Grove Community and Technical College  Minneapolis Community and Tech College  Rochester Community and Tech College  South Central Tech – Mankato  St. Catherine University  Normandale Community and Tech College |
| MHCP Applicant Assurance Statement | This is required.  MHCP Applicant Assurance Statement – Community Health Workers (DHS-5308) |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.3.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.3.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.3.1.1.

## Run Business Rules on Clinical Nurse Specialist

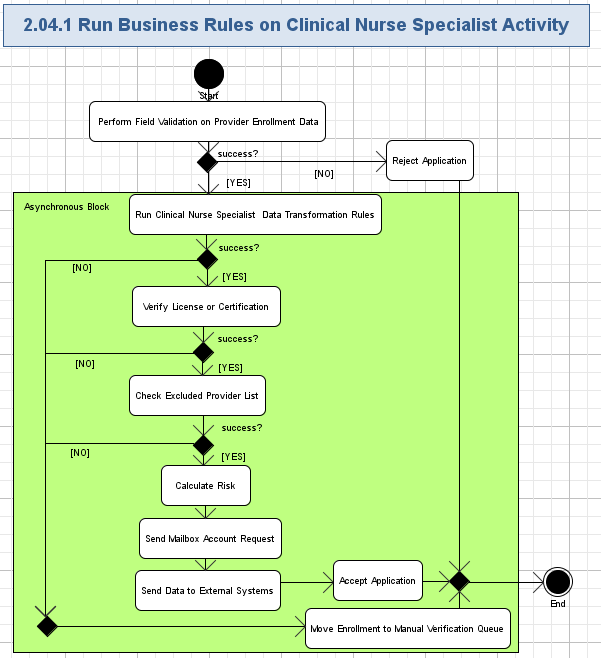
The system will run business rules on the “Clinical Nurse Specialist” provider type (the type number is 68). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.5

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Clinical\_Nurse\_Specialist\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Clinical Nurse Specialist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Specialty | The Specialty name of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Clinical Nurse Specialist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 68 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| Education level/Date | Masters = 1  Doctorate = 2  Date of Degree  Required only he/she is certified as a Psychiatric/Mental Health provider. |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following programs: AC BB FF GM HH IM JJ KK LL MA NM QM RM EH FP DM |
| Specialties | 82 = Psychiatric/Mental Health Specialty  If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list below (in exceptions) |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Clinical Nurse Specialists are to receive the following Categories of Service: 032, 034, 043, 051, 053, 054, 058, 075, 076, 079, 080, 092, 124  If Psychiatric / Mental Health Specialty indicated:  Include: 034, 035, 043, 046, 117  If provider signed Child & Teen Checkup Agreement (DHS-4646):  Add: 040, 078 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "40."  The state is "XX" since ASHA is a national certification.  Skip the VER LTR and BOARD fields.  Also skip restrict and certification verified steps below if pending certification verification.  When verification has been received, enter information.  In the RESTRICT column, enter "A" to indicate an active file.  Enter "Y" to indicate that the certification has been verified. |
| RN License | MN RN license in the following format: R123456-7 |
| License type | RN = 64  CNS = 68 (XX in State field) |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Nurse Licensure Compact | If the provider is licensed and resides in one state, but practices in another, the license is accepted IF both states participate in the Nurse Licensure Compact. Minnesota does not participate in the NLC, so if the provider practices in MN, they must have a MN RN license and their MN RN license is not accepted in any other state. Example: Provider resides and is licensed in South Dakota (an NLC state) but practices in North Dakota (an NLC state). Provider MUST be licensed in state of permanent residency. |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Registered Nurse License | This is required. |
| Clinical Nurse Specialist Certification | Clinical Nurse Specialist Certification from the American Nurses Credentialing Center, or other accepted National Board |
| NPI | This is required. |
| Child & Teen Checkup Agreement (DHS-4646) | This is optional. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.4.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.4.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.4.1.1.

## Run Business Rules on Certified Registered Nurse Anesthetist

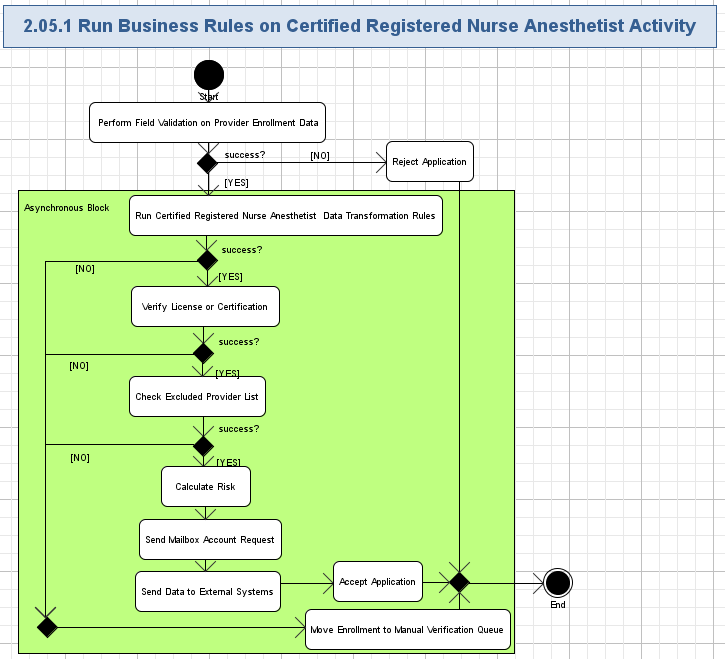
The system will run business rules on the “Certified Registered Nurse Anesthetist” provider type (the type number is 67). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.6

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Certified\_Registered\_Nurse\_Anesthetist\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Certified Registered Nurse Anesthetist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Specialty | The Specialty name of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Certified Registered Nurse Anesthetist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 67 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Specialties | If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list below (in exceptions). |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Certified Registered Nurse Anesthetists are to receive the following programs: BB FF GM IM JJ KK LL MA NM QM RM XX EH FP DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Certified Registered Nurse Anesthetists are to receive the following Categories of Service: 041, 043 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is “40.”  The state is “XX” since ASHA is a national certification.  Skip the VER LTR and BOARD fields.  Also skip restrict and certification verified steps below if pending certification verification.  When verification has been received, enter information.  In the RESTRICT column, enter "A" to indicate an active file.  Enter "Y" to indicate that the certification has been verified. |
| License type | RN = 64  CRNA = 67 (XX in State field) |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Nurse Licensure Compact | If the provider is licensed and resides in one state, but practices in another, the license is accepted IF both states participate in the Nurse Licensure Compact. Minnesota does not participate in the NLC, so if the provider practices in MN, they must have a MN RN license and their MN RN license is not accepted in any other state. Example: Provider resides and is licensed in South Dakota (an NLC state) but practices in North Dakota (an NLC state). Provider MUST be licensed in state of permanent residency. |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Registered Nurse License | This certificate is required. |
| CRNA Certification from the American Association of Nurse Anesthetists | The certificate is required. |
| NPI | Required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.5.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.5.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.5.1.1.

## Run Business Rules on Chiropractor

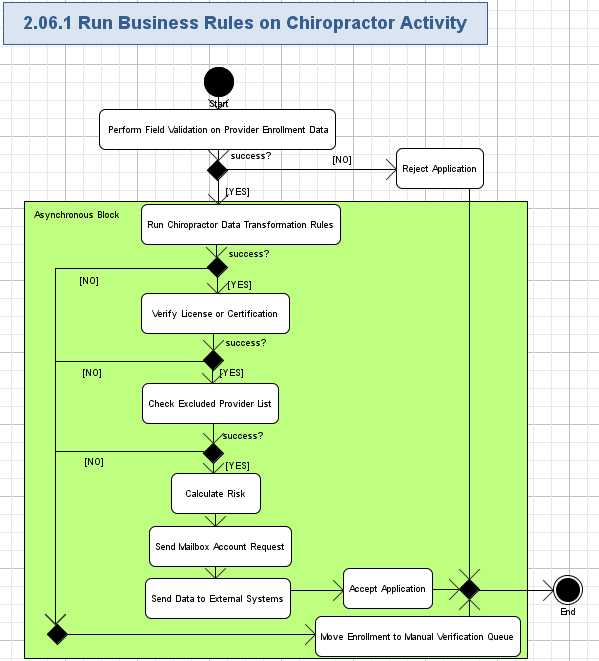
The system will run business rules on the “Chiropractor” provider type (the type number is 37). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.7

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Chiropractor\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Chiropractor Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Chiropractor Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 37 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Specialties | If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list below (in exceptions). |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Chiropractors are to receive the following programs: BB, FF, GM, IM, JJ, KK, LL, MA, NM, QM, RM, XX, EH, DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Chiropractors are to receive the following Categories of Service: 043, 057, 079 |
| **PLIC** | |
| license number | Enter the license number for the state of practice as shown on the copy of the license. |
| BEGIN DT | Begin date of as shown on the copy of the license. |
| EXP DT | End date if shown on the copy of the license |
| TYPE | License type is “37" |
| STATE | Abbreviation of state in which license was granted |
| RESTRICT | “A” to indicate an active |
| VERIFIED | “Y” if the license has been verified;  if not, “N”, making sure upon activation of the provider number that the verification is changed to “Y. |
| **PGRP** | |
| BEGIN DT | Date in which the provider joined the group affiliation. |
| END DT | Date in which the provider left the group affiliation. |
| GROUP NBR | group number of the practice the provider is affiliated. The group’s MA provider number should be entered |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Copy of the provider’s current Minnesota license from the Minnesota Board of Chiropractic Examiners | This certificate is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.6.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.6.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.6.1.1.

## Run Business Rules on Podiatrist

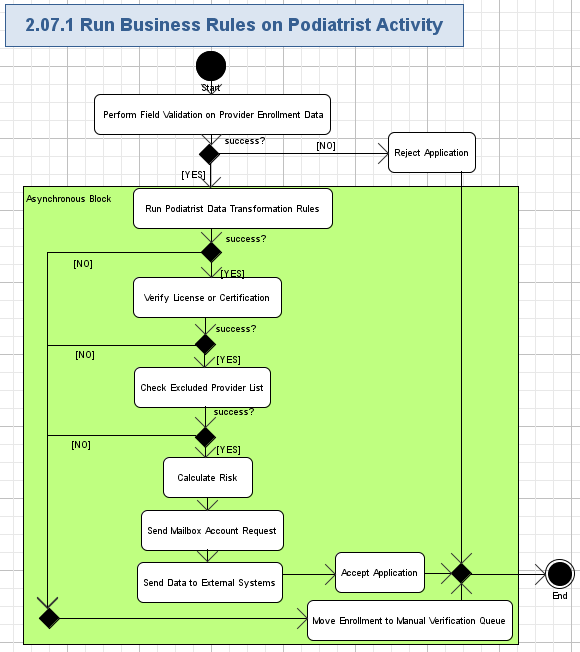
The system will run business rules on the “Podiatrist” provider type (the type number is 36). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.8

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Podiatrist\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Podiatrist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Podiatrist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 36. |
| Federal Tax ID number | Federal Tax ID number only if individual is in private practice and does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PROL** | |
| NPI | The provider’s NPI as it is required for this provider type.  Often, an actively enrolled provider will submit an application through a different practice from that showing in the provider’s file. It then is necessary to determine whether the provider’s primary place of practice has changed (thus treating the application as a change of address) or whether the provider’s currently listed practice address remains the same and the provider merely should be affiliated with the group showing on the new application. Determine this by calling or writing to the provider’s office. If the provider should be affiliated with the new group, do not change addresses or the tax identification already in the record, but go to the PGRP screen and add the relevant affiliation information. |
| EFF DATE | The same effective date as on the PADD screen. If it is for a future date, use today’s date. |
| END DATE | leave blank |
| ROLLED UP | The indicator for individuals is always N. If provider has two specialties that cannot be combined into single record, see procedures for creating consolidated individual providers. |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| DHS CCONSULT IND | Skip |
| Provider DOB | Date of birth, required |
| PAY METHOD | This field defaults to M for Mail check. Individuals and groups, direct provider to MMB for information on direct deposit. |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Podiatrists are to receive the following programs: BB, FF, GM, IM, JJ, KK, LL, MA, NM, QM, RM, XX, DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Podiatrists are to receive the following Categories of Service: 032, 043, 051, 055, 076, 079, 080 |
| **PLIC** | |
| license number | The license number for the state of practice as shown on the copy of the license. |
| BEGIN DT | Begin date of as shown on the copy of the license. |
| EXP DT | End date if shown on the copy of the license. |
| Type | 36 |
| STATE | Abbreviation of state in which license was granted. |
| VER LTR | Skip |
| BOARD | Skip |
| RESTRICT | A to indicate an active file or T to indicate temporary licensing. |
| VERIFIED | A@ if the license has been verified; if not, enter N, making sure upon activation of the provider number that the verification is changed to Y. |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| BEGIN DT | Date in which the provider joined the group affiliation. |
| END DATE | Leave open unless updated provider file and the provider has left the group practice |
| GROUP NBR | group number of the practice the provider is affiliated. The group’s MA provider number should be entered |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Copy of license as a podiatrist from the MN Board of Podiatric Medicine | This is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.7.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.7.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.7.1.1.

## Run Business Rules on Licensed Marriage and Family Therapist

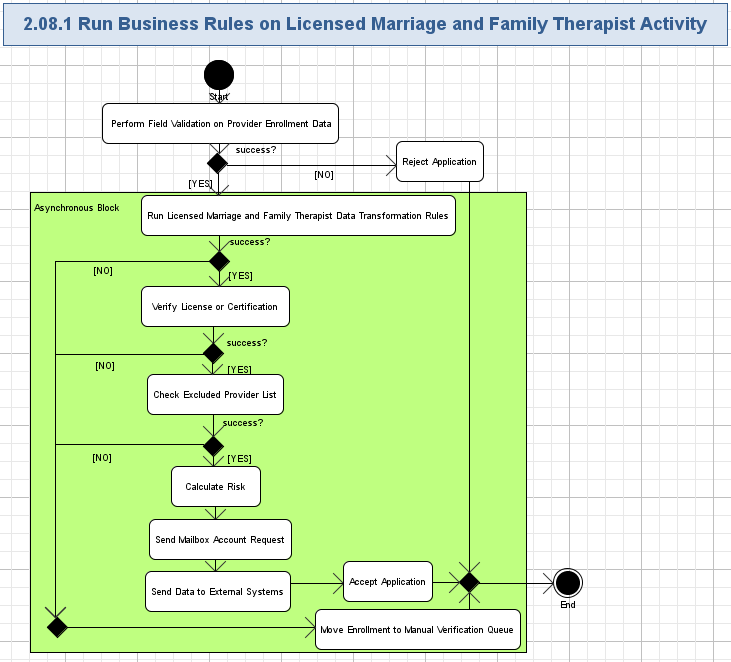
The system will run business rules on the “Licensed Marriage and Family Therapist” provider type (the type number is 25). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.9

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Licensed\_Marriage\_and\_Family\_Therapist\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Licensed Marriage and Family Therapist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info** | | | |
| Highest Degree Earned | The highest degree earned by the provider. | String, max 50 chars, non empty. | Y |
| Date Degree Awarded | The date when the Degree is awarded. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Licensed Marriage and Family Therapist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 25 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| Education level and date | Masters = 1  Doctorate = 2  Date of Degree |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  A Licensed Marriage and Family Therapist is to receive the following programs: BB EH FF GM HH IM JJ KK LL MA NM QM RM XX DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  A Licensed Marriage and Family Therapist is to receive the following Categories of Service: 043, 046, 117 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "25." |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Dual licensed providers | A number of mental health providers are licensed from multiple boards. Providers who are licensed as an LMFT and an LICSW, or LPCC are enrolled with MHCP as LICSWs. Add COS 117 if also an LMFT. |
| Providers | Providers who are also licensed as Psychologists are enrolled an LP.  Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice.  Reservation:  FL = Fond Du Lac Indian Reservation  GP = Grand Portage Indian Reservation  LL = Leech Lake Indian Reservation  ML = Mille Lacs Indian Reservation  NL = Net Lake Indian Reservation  PI = Prairie Island Indian Reservation  RL = Red Lake Reservation  US = Upper Sioux Indian Reservation  WE = White Earth Indian Reservation  LS = Lower Sioux Indian Reservation |
| **Out of State Providers** | |
| Licensed Marriage and Family Therapist | To be considered as an Licensed Marriage and Family Therapist in the MN Medicaid program, the provider has to meet the same requirements set for MN LMFTs:  The provider must have a Masters in Social Work (MSW).  The provider must be licensed as a Marriage & Family Therapist, or an equivalent that satisfies Minnesota’s statutory license requirements.  North Dakota = LPCC or LMFT |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Current license from state of practice | Individuals who practice in Minnesota must be licensed as a Marriage & Family Therapist from the MN Board of Marriage & Family Therapy. Out-of-state providers must meet the MN board's criteria for licensure. NOTE: See below for out-of state providers. |
| NPI | This is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.8.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.8.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.8.1.1.

## Run Business Rules on Licensed Professional Clinical Counselor

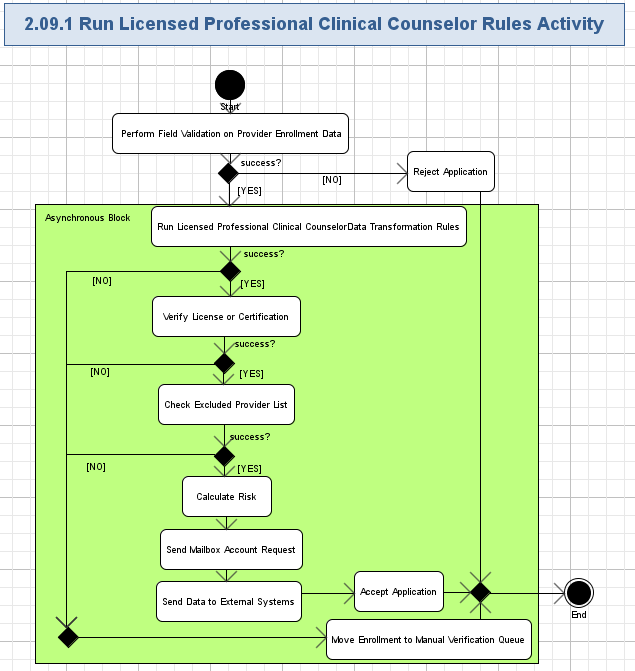
The system will run business rules on the “Licensed Professional Clinical Counselor” provider type (the type number is 63). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.2

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Licensed\_Professional\_Clinical\_Counselor\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Licensed Professional Clinical Counselor Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info** | | | |
| Highest Degree Earned | The highest degree earned by the provider. | String, max 50 chars, non empty. | Y |
| Date Degree Awarded | The date when the Degree is awarded. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Licensed Professional Clinical Counselor Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 42 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| education level and date | Masters = 1  Doctorate = 2  Date of Degree |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  All Licensed Professional Clinical Counselors are to receive the following programs: BB EH FF GM HH IM JJ KK LL MA NM QM RM XX DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  All Licensed Professional Clinical Counselors are to receive the following Categories of Service: 034, 035, 043, 046 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "CC" |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Dual licensed providers | A number of mental health providers are licensed from multiple boards. Providers who are licensed as an LPCC and an LMFT are enrolled as LPCC with an additional COS of 117. If licensed as LICSW, enroll as LICSW. |
| Providers | Providers who are also licensed Psychologists are enrolled as an LP.  Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Out of State Providers** | |
| Out of State Providers | According to the information about reciprocity on the MN Board of Behavioral Health and Therapy website, the only state with an equivalent license is Virginia (LPC). North Dakota has an LPCC license which is equivalent to Minnesota’s LMFT. Enroll North Dakota LPCCs as Provider Type 25. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Current license from state of practice | This certificate is required. |
| NPI | Required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.9.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.9.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.9.1.1.

## Run Business Rules on Licensed Psychologist

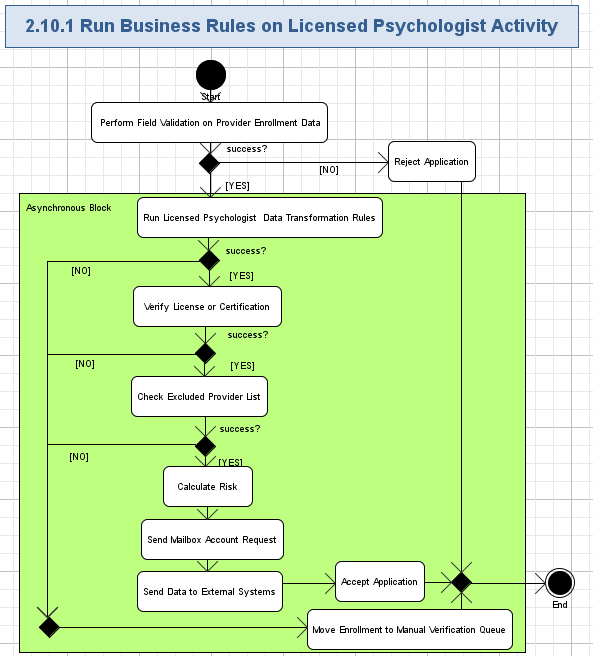
The system will run business rules on the “Licensed Psychologist” provider type (the type number is 42). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 1: 3.1.1 and 3.1.10

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Licensed\_Psychologist\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Licensed Psychologist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info** | | | |
| Highest Degree Earned | The highest degree earned by the provider. | String, max 50 chars, non empty. | Y |
| Date Degree Awarded | The date when the Degree is awarded. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Licensed Psychologist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 42 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12   1. = BOTH-DMZ-X12 |
| education level and date | Masters = 1  Doctorate = 2  Date of Degree |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Licensed Psychologists are to receive the following programs: BB EH FF GM HH IM JJ KK LL MA NM QM RM XX DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Licensed Psychologists are to receive the following Categories of Service: 034, 035, 043, 046, 050, 117 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "42." . |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Dual licensed providers | A number of mental health providers are licensed from multiple boards. Providers who are licensed as a Psychologist and an LMFT, LICSW, or LPCC are enrolled with MHCP as Psychologists. |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Current license from state of practice | Required. |
| NPI | Required. |
| Copy of registration with Department of Health | The registration is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |
| If Neuropsychology specialty is indicated | |
| Received a diploma from one of the following boards or academies | American Board of Clinical Neuropsychology (ABCN)  America Board of Professional Neuropsychology (ABPN), or  American Academy of Pediatric Neuropsychology (AAPN) |
| Earned a doctoral degree in psychology from an accredited university training program and | 1.Completed an internship or its equivalent, in a clinically relevant area of professional psychology  2.Completed the equivalent of two full-time years of experience and specialize training, at least one which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist  3.Holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 – 148.98 |
| Been licensed or credentialed by another state’s board | Been licensed or credentialed by another state’s board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named earlier |
| Been approved by the commissioner | Been approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010, (enrolled in MHCP with neuropsychology specialty) |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.10.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.10.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.10.1.1.

## Run Business Rules on Physician

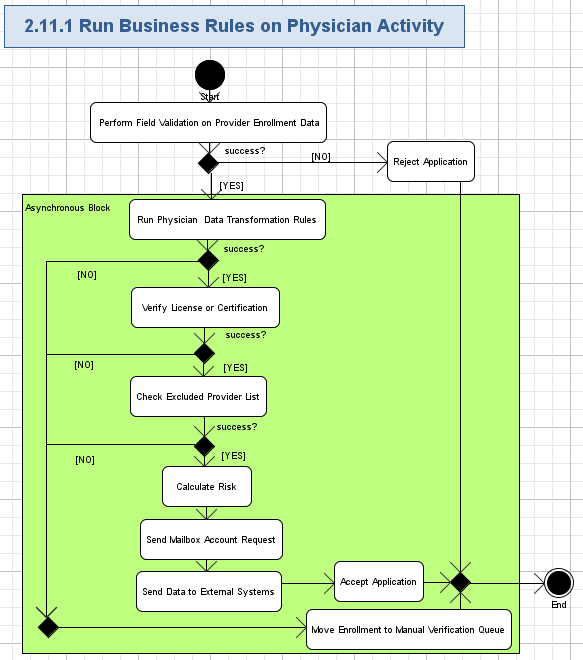
The system will run business rules on the “Physician” provider type (the type number is 20). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.3

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Physician\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Physician Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Request Effective Date | The date when the request is effective. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Highest Degree Earned | The highest degree earned by the provider. | String, max 50 chars, non empty. | Y |
| Date Degree Awarded | The date when the Degree is awarded. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Phone Number | The phone number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Fax Number | The fax number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Phone Number | The contact phone number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Contact Fax Number | The contact fax number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Specialty | The Specialty name of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification File | The copy file of the License/Certification. | Image, max 2M. | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Mailing(Alternate Mailing Addresses)** | | | |
| Remittance Advice | The address of Remittance Advice | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Reimbursement Check | The address of Reimbursement Check | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Provider Correspondence | The address of Provider Correspondence | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Authorization Request Notice and Service Agreements | The address of Authorization Request Notice and Service Agreements | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Credentials Enrollment Status | The address of Credentials Enrollment Status | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Remittance Advice | The address of Remittance Advice | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Physician Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 20 |
| Practice type | = 01 |
| Agreement Type | Agreement Type = 1 for standard enrollment, 2 for Stipulated Agreements received from Mayo Clinic (these providers must sign and submit a Standard Agreement before affiliating with other organizations.) |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  All Physicians are to receive the following programs: AC BB FF GM IM JJ KK LL MA NM QM RM XX EH FP DM |
| specialties | A Physician must enter their:  SPECIALTIES:  11 = Allergy  41 = Anesthesiology  12 = Cardiovascular Disease  91 = Cardiovascular Surgery  21 = Child Psychiatry  50 = Colon and Rectal Surgery  13 = Dermatology  06 = Diabetes  05 = Emergency Services  42 = Endocrinology  77 = Family Practice  14 = Gastroenterology  01 = General Practice  51 = General Surgery  43 = Gerontology  47 = Gynecology  44 = Immunology  72 = Infectious Disease  15 = Internal Medicine  92 = Nephrology  52 = Neurological Surgery  22 = Neurology  76 = Nuclear Medicine  46 = Obstetrics  53 = Obstetrics and Gynecology  60 = Oncology  54 = Ophthalmology  31 = Pathology  16 = Pediatrics  74 = Peripheral Vascular Diseases or Surgery  17 = Physical Medicine and Rehabilitation  57 = Plastic Surgery  18 = Preventive Medicine  23 = Psychiatry  19 = Pulmonary Disease  32 = Radiology  76 = Radiology and Radiation Therapy  90 = Rheumatology  58 = Thoracic Surgery  59 = Urology  99 = Other  QS = For Psych Specialty providers who signed a Qualified Mental Health Supervision AAS (DHS-6330)  Effective no earlier than 6-28-2011 |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  All Physicians are to receive the following Categories of Service: 032, 034, 041, 043, 045, 046, 051, 054, 058, 075, 076, 079, 080, 092, 117, 124  Add if provider signed Child & Teen Checkup Agreement (DHS-4646):  040  Add if provider indicates Ophthalmology (54), family practice (77), or pediatrics (16) specialty:  078  Providers may request 053  Add an end date if provider submitted Temporary MD License. Remove end date when permanent license is received. |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "22."  The state is "XX" since ASHA is a national certification.  Skip the VER LTR and BOARD fields.  Also skip restrict and certification verified steps below if pending certification verification.  When verification has been received, enter information.  In the RESTRICT column, enter "T" to indicate an active file.  Enter "Y" to indicate that the certification has been verified, “T” if temporary license |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| provider | If the provider is licensed and resides in one state, but practices in another, the license is accepted IF both states participate in the Nurse Licensure Compact. Minnesota does not participate in the NLC, so if the provider practices in MN, they must have a MN RN license and their MN RN license is not accepted in any other state. Example: Provider resides and is licensed in South Dakota (an NLC state) but practices in North Dakota (an NLC state). Provider MUST be licensed in state of permanent residency. |
| Public Health Service (PHS) Indian Hospital | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Physician license in state of practice | This is required. |
| NPI | Required |
| Specialty Certification | Required if Physician selects a specialty |
| Child & Teen Checkup Agreement (DHS-4646) | Optional |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.11.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.11.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.11.1.1.

## Run Business Rules on Nurse Practitioner

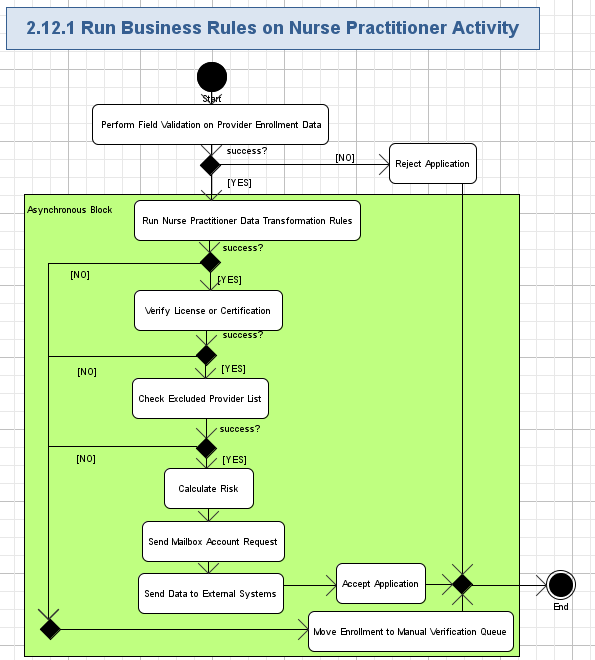
The system will run business rules on the “Nurse Practitioner” provider type (the type number is 65). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.4

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Nurse\_Practitioner\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Nurse Practitioner Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Request Effective Date | The date when the request is effective. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Phone Number | The phone number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Fax Number | The fax number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Phone Number | The contact phone number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Contact Fax Number | The contact fax number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info** | | | |
| Copy of your Physician License | The copy file of the Physician License | Image, max 2M. | Y |
| Copy of your specialty certification | The copy file of the specialty certification | Image, max 2M. | Y |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Specialty | The Specialty name of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Nurse Practitioner Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 65 |
| Nurse Practitioners | This provider type can be a group, but must be composed of at least two enrolled Nurse Practitioners. |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N.  "N" for BRDR if practice address is either in Minnesota or outside of the border state area.  "Y" for BRDR if the practice address is located in a bordering state. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| education level and date | Masters = 1  Doctorate = 2  Date of Degree  Only if the provider is certified as a Psychiatric/Mental Health Specialty. |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  A Nurse Practitioner is to receive the following programs: AC BB EH FF GM IM JJ KK LL MA NM QM RM DM FM |
| Specialties | 33 = Gerontological NP  34 = Pediatric NP  35 = Family NP  37 = Adult NP  80 = OB/GYN  82 = Psychiatric/Mental Health Specialty  94 = Neonatal NP  96 = Women’s Health Care NP  97 = Acute Care NP  If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list below (in exceptions). |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  A Nurse Practitioner is to receive the following Categories of Service: 032, 034, 043, 076, 079, 080, 089, 091, 092, 097  If Psychiatric / Mental Health Specialty indicated:  Add: 034, 035, 043, 046, 080, 091, 117  If provider signed Child & Teen Checkup Agreement (DHS-4646):  Add: 040, 058, 078 |
| **PLIC** | |
| license number | The license number should be entered as stated on the certificate copy.  The begin date should be entered as stated and the end date left to default.  (License) TYPE is "64."  The state is "XX" since ASHA is a national certification.  Skip the VER LTR and BOARD fields.  Also skip restrict and certification verified steps below if pending certification verification.  When verification has been received, enter information.  In the RESTRICT column, enter "A" to indicate an active file.  Enter "Y" to indicate that the certification has been verified. |
| For any specialties selected | Certification type (XX in State field):  65 = Adult NP  71 = Gerontological NP  72 = Pediatric NP  73 = Family NP  74 = OB/GYN NP  75 = Neonatal NP  76 = Women’s Health Care NP  78 = Acute Care NP  82 = Mental Health Specialty |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Exceptions** | |
| Nurse Licensure Compact | If the provider is licensed and resides in one state, but practices in another, the license is accepted IF both states participate in the Nurse Licensure Compact. Minnesota does not participate in the NLC, so if the provider practices in MN, they must have a MN RN license and their MN RN license is not accepted in any other state. Example: Provider resides and is licensed in South Dakota (an NLC state) but practices in North Dakota (an NLC state). Provider MUST be licensed in state of permanent residency. |
| Public Health Service (PHS) Indian Hospital | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code (see appendix 5.1) to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Registered Nurse license in state of practice | This is required. |
| Nurse Practitioner Certification from the American Nurses Credentialing Center, American Academy of Nurse Practitioners, Pediatric Nursing Certification Board, or other accepted National Board | Required. |
| NPI | Required |
| Child & Teen Checkup Agreement (DHS-4646) | Optional |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.12.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.12.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.12.1.1.

## Run Business Rules on Occupational Therapist

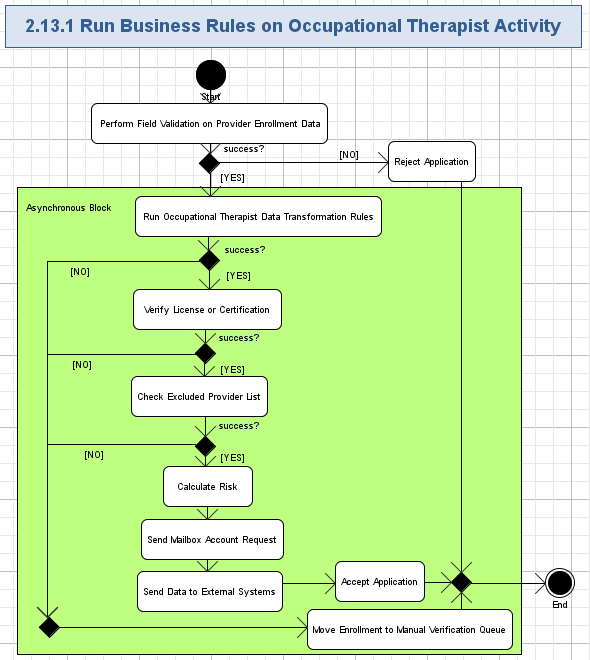
The system will run business rules on the “Occupational Therapist” provider type (the type number is 29). The business rules will include validation rules and screen rules. The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.5

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Occupational\_Therapist\_.html

* Pre-conditions: the user submitted the provider application form.
* Post-conditions: the system accepted application from the provider or rejected the application from the provider.

### Run Business Rules on Occupational Therapist Activity



#### Perform Field Validation on Provider Enrollment Data

* The system will perform field validation on the provider enrollment data.
* The enrollment data submitted from the provider will follow the rules described below:

| **Data Element** | **Description** | **Format** | **R?** |
| --- | --- | --- | --- |
| **Personal Info** | | | |
| Last Name | The last name of the user. | String, max 50 chars, non empty. | Y |
| First Name | The first name of the user. | String, max 50 chars, non empty. | Y |
| Middle Name | The middle name of the user. | String, max 50 chars, can be empty. | N |
| NPI | The NPI of the user. | String, 20 chars, non empty | Y |
| Social Security Number | The Social Security Number of the user. | String, 10 chars, non empty | Y |
| Date of Birth | The birth date of the user. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Request Effective Date | The date when the request is effective. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Phone Number | The phone number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Fax Number | The fax number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Email | The e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| <Same as above> | The checkbox to indicate if the following fields can be same as above.  Note: the user does not need to enter the same information. | Checkbox. | Y |
| Contact Name | The contact name of the user. | String, 100 chars, non empty | Y |
| Contact Phone Number | The contact phone number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Contact Fax Number | The contact fax number of the user. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Contact Email | The contact e-mail address of the user. | String, max 100 chars, must be a valid e-mail, can be empty | N |
| **License Info** | | | |
| Copy of your Occupational Therapist License | The copy file of the Occupational Therapist License. | Image, max 2M. | Y |
| Copy of your NBCOT (National Board for Certification in Occupational Therapy) certificate | The copy file of the NBCOT. | Image, max 2M. | Y |
| **License Info (List of records)** | | | |
| # | The number of the license information record. | String, 100 chars, non empty | Y |
| Specialty | The Specialty name of the license information record. | String, 100 chars, non empty | Y |
| Type of  License/Certification | The type of the License. | String, 100 chars, non empty | Y |
| License/Certification # | The number of the license. | String, 100 chars, non empty | Y |
| Original Issue Date | The date when the license was original issued. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Renewal End Date | The date when the license was renewal. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| Issuing State | The state of the issuing. | String, 20 chars, non empty | Y |
| **Practice Info** | | | |
| Do you maintain your own private practice? | The question to ask if the user maintains her/his own private practice | Boolean, Yes/No. | Y |
| Are you employed and/or independently contracted by a group practice? | The question to ask if the user is employed. | Boolean, Yes/No. | Y |
| Private Practice Name | The private name of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Primary Practice Name | The name of the primary practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty.  This field is required ONLY if the answer for the first question is “No” | Y |
| Practice Address | The address of the practice. | String, 100 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Practice Phone Number | The phone number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, non empty | Y |
| Practice Fax Number | The fax number of the practice. | String, like “xxx xxx-xxxx” ext “xxx”, where “x” is a digit [0-9], max 20 chars, can be empty | N |
| Billing Address | The billing address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “Yes” | Y |
| FEIN | The FEIN of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| State Tax ID | The state tax id of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Fiscal Year End | The date of the fiscal year end. | String, 10 chars, non empty.  Date format: MM/DD  This field is required ONLY if the answer for the first question is “Yes” | Y |
| EFT Vendor Number | The number of the EFT vendor. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Remittance Sequence | The remittance sequence of the practice. | String, 100 chars, non empty  This field is required ONLY if the answer for the first question is “Yes” | Y |
| Reimbursement Address | The Reimbursement Address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information.  This field is required ONLY if the answer for the first question is “No” | Y |
| **Additional Locations** | | | |
| Group NPI / UMPI | The NPI/UMPI of the group of the practice. | String, 100 chars, non empty. | Y |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Practice Address | The address of the practice. | String, 400 chars, non empty.  This field includes address, state, city, country and zip code information. | Y |
| Effective Date | The date when the location was effective | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |
| **Provider Statement** | | | |
| Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Have you ever been convicted of a criminal offense related to involvement in any program underMedicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs? | Boolean, Yes/No. | Y |
| Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Have you had civil money penalties or assessments imposed under section 1128A of the Social Security Act? | Boolean, Yes/No. | Y |
| Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Have you ever been excluded or terminated from participation in Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or the Title XXI services program in Minnesota or any other state since the inception of these programs? | Boolean, Yes/No. | Y |
| Provider Statement | The description of the statement. | String, 1024 chars, non empty | Y |
| Provider Name | The name of the provider. | String, 100 chars, non empty | Y |
| Provider Title | The title of the provider. | String, 100 chars, non empty | Y |
| Provider Signature: | The signature of the provider. | Image. | Y |
| Date | The date when the statement was made. | String, 10 chars, non empty.  Date format: MM/DD/YYYY | Y |

#### Reject Application

* The system will reject the application from the provider if the field validation is not successful.
* The provider needs to provide the enrollment data again to register the enrollment.

#### Run Occupational Therapist Data Transformation Rules

* The system will run specific data transformation rules (including name and address consistency rules) on the enrollment data from the provider:

| **Application Element** | **Rules** |
| --- | --- |
| **Name and Address Consistency** | |
| **Individual Names** | |
| Standard Individual Names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Last names with apostrophe's | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS.  And the last name contains the apostrophe  Example: JAMES MICHAEL O'CONNOR MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  And the last name does contain the apostrophe  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Hyphenated last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST-LAST  Example:  NANCY WISE-VANDERLEE MD |
| SORT NAME | This field contains:  LASTLAST, FIRST, MIDDLE  Example : WISEVANDERLEE NANCY  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Double last names | |
| NAME | This field contains:  FIRST, MIDDLE, LAST LAST  Example:  MICHELLE LYNN CARLSON OLSON |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE, LAST  Example : OLSON MICHELLE LYNN CARLSON  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| Names with spaces | Remove the spaces:  MAC KENZIE = MACKENZIE  MC DONALD = MCDONALD |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Organizational Names** | |
| Standard Organizational Names | |
| NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES PHYSICIANS CLINIC |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| Organizations using an individual name | |
| NAME | This field contains:  FIRST, MIDDLE, LAST, CREDENTIALS  Example: JAMES MICHAEL OLSON MD |
| SORT NAME | This field contains:  LAST, FIRST, MIDDLE  Example : OLSON JAMES MICHAEL  Note: title should not be used in this field. |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| School Districts | |
| NAME | This field contains name of school district  Example: MINNESOTA STATE ACADEMIES |
| SORT NAME | This field contains independent school district number for sorting purposes  Example: ISD #0160 |
| INST OWNER | This field should be blank unless the provider owns the FEIN;  It should be same name as it is registered with the IRS if present. |
| General Rules | |
| punctuation | No punctuation will be used in the SORT or INST OWNER fields. |
| **Addresses** | |
| Streets | 1. Leave Address Line 1 blank. Only use Address Line 1 if Address Line 2 is too long. 2. When it’s necessary to use both Line 1 and Line 2: Use Line 1 for the street address and Line 2 for the Suite, PO Box, or other identifying location. 3. Do not spell out the name of a direction of a street. Use N, E, S, W, SW, SE, NW, and NE. 4. If the name of the street is a direction, then spell out the name.   Address Word Abbreviation List:  APARTMENT = APT  CIRCLE = CIR  HIGHWAY = HWY  AVENUE = AVE  COUNTY = COUNTY  POST OFFICE BOX = PO BOX, = PO BOX  OR POB  BUILDING = BLDG  COURT = CT  STREET = ST  C/O = %  DEPARTMENT = DEPT  SUITE = STE  CENTER = CTR  DIVISION = DIV  ROAD = RD  BOULEVARD = BLVD  DRIVE = DR |
| Cities | 1. Spell out the city name – MINNEAPOLIS 2. Spell out North, South, West before the name of the city - NORTH ST PAUL, EAST GRAND FORKS   City Word Abbreviation List:  SAINT: ST (EXAMPLE: SAINT LOUIS = ST LOUIS)  HEIGHTS: HTS  LAKE: LK  INTERNATIONAL: INTL  JUNCTION: JCT  TAIL: TL |
| **Enrollment Data** | |
| **PADD** | |
| Provider Type | Provider Type = 29 |
| Federal Tax ID number | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI. |
| SSN | This field is required. |
| Provider Name | This field contains: first, middle (if given), last |
| MN TAX ID | This field is present only if individual is in private practice and is not affiliated with a group practice that does not have a Type 2 NPI |
| UPIN | Leave UPIN blank (Audiologists are not given UPINs) |
| Address | Three lines exist for the provider's address.  The street address and suite number (if given) should be entered on the second line, denoted by "(1)," unless the provider lists a P.O. Box in his/her address.  In this case, the street address should be entered on the first line and the P.O. Box entered on the second line.  A street address must accompany the P.O. Box, the provider manual is not deliverable to a P.O. Box.  This is also the provider’s practice address field and a P.O. Box (only) is not acceptable.  The third line has clearly defined categories for city, state, and zip code |
| CORR DATE RECD | Date application was received, this field should be present. |
| FISCAL YEAR END | Default to 12/31, this field is required. |
| Country Code | This field is three-digit code for the county that is required. |
| BRDR | This field should be Y or N. |
| Practice type | This field should be "01". |
| Telephone Number | This field is required and should include area code. |
| Fax Number | This field is required and should include area code. |
| SELF RESTRICT IND. | This field should be empty. |
| MEDICAID PART IND | This field should be Y |
| MEDICARE PART IND | This field should be empty. |
| Ownership code | This field is required.  For example, "1" indicates a non-profit organization, and "2" means privately owned. |
| APP DT | This field is required.  The date when application is entered on to the system. |
| MEDICAID AGMT | This field should be “1” |
| BILL AGMT | This field should be empty. |
| AFFIRM ACT IND | This field is required. |
| Sort name | It should be listed in the following order: last name, first, middle, no punctuation. Sort name indicates how this provider’s name will be listed in alphabetical order during a name search. The sort name is the name that is used when inquiring into the system by name. |
| DRIVERS LICENSE | This field should be empty. |
| INST OWNER | INST OWNER should be whoever owns the FEIN listed on this provider's file. If no tax ID number is listed, then it should be the provider's name. |
| Provider Status | Provider is automatically placed in "U" status, which indicates that the provider number is pending. Some other pending status should be used if the provider cannot be enrolled immediately. Generally, status “S” (pending agreement) or “W” (pending license verification) should be used. Occasionally, some other problem may appear on the application - particularly neglect to put certain important information on the application; in those cases use status “T” (incomplete). The system will generate a letter to be sent to the applicant to request the additional information. The system will not generate a letter regarding a pending status on a provider who is terminated and seeking reinstatement; all correspondence regarding deficiencies in such applications must be generated on Word.  The pending status will be changed to a “1" (or a “2" if the application is for reinstatement) when the application is complete and there is a signed provider agreement. |
| BEGIN DT | The effective date (BEGIN DT) will be the first day of the month of application, unless a different date is requested because services have already been provided. (The provider's effective date may be retroactive over one year, as long as the provider's certification number was active at that time, but Claims Processing will usually deny payment on claims over 12 months old.) |
| END DT | The END DT should be left blank. (The default date will be 99/99/99.) |
| **PINF** | |
| REMIT SEQ | If the provider has checked any of the three blanks, enter the corresponding numbers in the "REMIT SEQ" column:  "4" = patient account or own reference number order;  "1" = DHS Transaction Control Number Order; or  "2" = recipient MHCP ID number order.  If this column is left blank, it will automatically revert to "0", which is alphabetical order by recipient name. |
| REMIT MEDIA | This field is auto-populated with the value of “N” on new provider records. If the provider registers for MN-ITS, the field will be updated to “P” through an MMIS job. Providers or DHS staff may request that a provider receives their remittance advice in a different format(s). Provider Enrollment will need to change the value in this field to correspond with the request. Please see the key below for values that are currently available.  B = BOTH-HARDCOPY-TAPE  C = CARTRIDGE  D = DISKETTE  F = FICHE  H = HARDCOPY-ONLY  N = NO-REMIT-ADVICE  P = PDF-835-ONLY  Q = BOTH-PDF-X12  R = X12-835-ONLY  T = TAPE-ONLY  X = BOTH-HDCPY-DISKETTE  Z = DISK-DMZ-SERVER  1 = BOTH-TAPE-X12  2 = BOTH-DISKETTE-X12  3 = BOTH-DMZ-X12 |
| **PPGM** | |
| Additional Address | Enter additional addresses on this screen if any are given. Use "1", "2", or "3" to indicate where warrants, remittance advices, prior authorizations and 1099s, should be sent. |
| Major Programs | Major Programs:  Begin Date: The begin date for the Major Programs will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following programs: BB, FF, IM, JJ, KK, LL, MA, NM, QM, RM, XX, EH, DM |
| **PCOS** | |
| Categories of Service | Categories of Service:  Begin Date: The begin date for Categories of Service will default to the same effective date entered on the PADD screen.  End Date: Leave the end date open.  Audiologists are to receive the following Categories of Service: 043, 053, 058 |
| **PLIC** | |
| license number | Enter the license number for the state of practice as shown on the copy of the license. Note: NBCOT (National Board for Certification of Occupational Therapy) is also required in addition to the state license. |
| BEGIN DT | Enter begin date of as shown on the copy of the license. |
| EXP DT | Enter end date if shown on the copy of the license. |
| TYPE | 29 |
| STATE | Abbreviation of state in which license was granted. If additional certification is national, enter XX. |
| **PGRP** | |
| Group Membership | Group Membership – Audiologists may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The EDI Unit provides this information. |
| **Enrollment Criteria** | |
| Licensure | Licensure as an occupational therapist in state of practice |
| Certification | Certification by the NBCOT (National Board for Certification in Occupational Therapy) |
| Note | Only OT’s in private practice are eligible for MHCP enrollment. If the OT is working for a hospital, a physician’s clinic or a Medicare-certified rehab agency, they are NOT eligible for MHCP enrollment. Also a therapist in private practice may not furnish covered services in a skilled nursing facility. Therefore, if a therapist wished to locate their private office on site at a nursing facility, the private office space may not be part of the Medicare participating SNF’s space and the therapist's services may only be furnished within the therapist’s private office space. |

#### Verify License or Certification

* The system will verify the license/certification information from the application form.
* The system will connect to the appropriate external system to verify them.
* The provider should have the following licenses/certifications:

| **Application Element** | **Rules** |
| --- | --- |
| Provider Agreement (DHS-4138) | The agreement should be agreed. |
| Copy of license as  Occupational Therapist in state of practice | This certificate is required. |
| Copy of certification by the NBCOT (National Board for Certification in Occupational Therapy) | The registration is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |

* If the validation is not successful, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Check Provider Lists

* The system will check the Exclusions list to verify if the user (the user information is retrieved from application) is in the list or not.
* If the user is found in the list, the application will be moved to the verification queue which will be handled by the service agents manually.

#### Calculate Risk

* The system will calculate the provider’s risk level.
* The risk levels will be determined by Medicare.

**Limited**

Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics  
Ambulatory surgical centers  
Competitive acquisition program/Part B vendors   
End-stage renal disease facilities   
Federally qualified health centers   
Histocompatibility laboratories   
Hospitals, including critical access hospitals, department of Veterans Affairs hospitals, and other federally owned hospital facilities  
Certain health programs operated by an Indian Health Program and urban Indian organizations   
Mammography screening centers   
Mass immunization roster billers   
Organ procurement organizations   
Pharmacies newly enrolling or revalidating via the CMS-855B application  
Radiation therapy centers   
Religious non-medical health care institutions   
Rural health clinics   
Skilled nursing facilities  
  
**Moderate**  
Ambulance service suppliers   
Community mental health centers  
Comprehensive outpatient rehabilitation facilities   
Independent clinical laboratories  
Independent diagnostic testing facilities  
Physical therapists enrolling as individuals or as group practices  
Portable x-ray suppliers  
Revalidating home health agencies   
Revalidation DMEPOS suppliers  
  
**High**  
Prospective (newly enrolling) home health agencies  
Prospective (newly enrolling) DMEPOS suppliers

* The calculation results will be stored to the database.

#### Send Data to External Systems

* Based on the risk level calculated, data will be passed to the appropriate systems:
  + High-risk:
    - SIRS (Surveillance & Integrity Review Section)
    - NetStudy Background Check
  + Moderate risk:
    - SIRS (Surveillance & Integrity Review Section)
  + Limited Risk:
    - Neither of the systems above
* The Enrollment Data sent to external systems is described in chapter 2.13.1.1.

#### Send Mailbox Account Request

* The application will connect to the MN-ITS Mailbox system and request a mailbox account is created for the user.

#### Move Enrollment to Manual Verification Queue

* The system will move the enrollment application to the verification queue which will be handled by the service agents manually.
* The Enrollment Data moved to queue is described in chapter 2.13.1.1.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.
* The Enrollment Data stored to the database is described in chapter 2.13.1.1.

# General Requirements

## Graphical User Interface Requirements

### Main GUI Goal

Please refer the following link for the wireframes:

<http://apps.topcoder.com/wiki/display/docs/CMS+-+Medicaid+Provider+Screening+Portal+-+Provider+Business+Rules+-+Part+1>

### Resolution

N/A

### Supported Browsers

N/A

## Performance Constraints

Performance Requirements:

* The application will have 24x7 availability
* All pages in the application should be loaded in 5 seconds or less after the initial hit.
* Medicaid Provider Screening Portal Application Performance
  + This project is for a component of the Medicaid Provider Screening Portal Application. The business process and screening rules in this document are built into the overall Medicaid Provider Screening Portal application so they will follow the performance requirements for the overall application.

## Security

### Security Roles

#### Permissions

N/A

#### Roles

The System user role was added for clarity.

|  |  |
| --- | --- |
|  | System |
| 2.1 Run Business Rules on Audiologist | X |
| 2.2 Run Business Rules on Certified Professional Midwife | X |
| 2.3 Run Business Rules on Community Health Care Worker | X |
| 2.4 Run Business Rules on Clinical Nurse Specialist | X |
| 2.5 Run Business Rules on Certified Registered Nurse Anesthetist | X |
| 2.6 Run Business Rules on Chiropractor | X |
| 2.7 Run Business Rules on Podiatrist | X |
| 2.8 Run Business Rules on Licensed Marriage and Family Therapist | X |
| 2.9 Run Business Rules on Licensed Professional Clinical Counselor | X |
| 2.10 Run Business Rules on Licensed Psychologist | X |
| 2.11 Run Business Rules on Physician | X |
| 2.12 Run Business Rules on Nurse Practitioner | X |
| 2.13 Run Business Rules on Occupational Therapist | X |

# Required Documentation

## Specification Documentation

* Requirements Specification (this document)
* High Level Use Case Diagrams
* Activity Diagrams
* Logical data model (as needed)
* Quality Assurance Plan (out of scope for this competition)

# Help / User Documentation

None at this time.

# Notes

None at this time.

# Future Enhancements

None at this time.

# Glossary

## Definitions

| **Definition** | **Description** |
| --- | --- |
| Categories of Service | Types of services the provider can provide |
| CHOW | Change of Ownership – Occurs when a business is sold and the new owner changes the FEIN and NPI. In that case, the old record is terminated and a new one is created. |
| Individual Practitioner Enrollment Application (DHS-4016) | A standard enrollment form for providers to fill out (the provider enrollment form in the current system). Used for collecting the majority of provider data for the enrollment and screening process. |
| Provider / Enrollee | The medical service provider who is using the new system to enroll or re-enroll through the Risk-Based Provider Screening process |
| Provider Agreement (DHS-4138) | A standard agreement form providers need to sign |
| Selected Providers | The specific provider types covered in this document (see list in section 1 above) |
| Specialties | Specialties are the specific services a provider can provide |

## Acronyms

|  |  |
| --- | --- |
| **Definition** | **Description** |
| CMS | Center for Medicaid Services |
| EFT | Electronic Funds Transfer |
| EPLS | Excluded Parties List System - EPLS provides a single comprehensive list of individuals and firms excluded by Federal government agencies from receiving federal contracts or federally approved subcontracts and from certain types of federal financial and nonfinancial assistance and benefits |
| GUI | Graphical User Interface |
| HCFA | Health Care Financing Administration (Sanctions List) |
|  |  |
| IT | Information Technology |
| Major programs | Major programs are the programs Medicaid covers |
| MMIS | Medicaid Management Information Systems - the current system in place today |
| MN-DHS | Minnesota Department of Human Services |
| MPSE | Medicaid Provider Screening and Enrollment |
| MPSP | Medicaid Provider Screening Portal |
| NetStudy | An external background check system |
| NPI | National Provider Identifier. Similar to a social security number, but for a health care provider. Instead of each insurance company assigning their own ID and the provider needing to keep track of them all, the NPI identifies them with everyone. Type 1 NPI is assigned to individuals, and type 2 is assigned to organizations. Not all providers are required to have an NPI. |
| NPPES | National Plan & Provider Enumeration System - NPI NPPES Registry Search Website is used to verify NPI numbers |
| PADD | PROVIDER ADDRESS (Screen Representing Data In The Current System) |
| PBCK | Provider Criminal Background Check |
| PCOS | Provider Categories Of Service |
| PEP | Provider Enrollment Processor (Frontend) |
| PFIN | Provider Financial Data |
| PGRP | Groups / Billing Agents |
| PIAPD | Planning and Implementation Advance Planning Document |
| PINF | Provider Information |
| PLIC | Provider Licenses |
| PMBR | Individual In Group |
| PPGM | Provider Programs / Alternate Mailing Address |
| PROL | Provider NPI |
| PVS | Provider Validation Service |
| SIRS | Surveillance & Integrity Review Section – An external system for site visits |
| UI | User Interface |
| UMPI | Unique Minnesota Provider Identifier. Assigned to providers that are required to have an NPI. |

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