**CMS - Medicaid Provider Screening Portal - Provider Business Rules - Part 2 1.0 Requirements Specification**

***This document outlines the Application Scope and Requirements for   
CMS - Medicaid Provider Screening Portal - Provider Business Rules - Part 2 1.0.***

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| |  |  | | --- | --- | | **PRESENTED TO:** <Client Names> | **<CLIENT LOGO>** | | **PRESENTED BY:** <TopCoder Names> | topcoder_logo | |

Revision History

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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.

* Physician Assistant
* Private Duty Nurse
* Physical Therapist
* Speech Language Pathologist
* Acupuncturist
* Allied Dental Professional
* Certified Mental Health Rehab Prof-CPRP
* Dentist
* Hearing Aid Dispenser
* Licensed Dietician or Licensed Nutritionist
* Licensed Independent Clinical Social Worker
* Nurse Midwife
* Optometrist

## 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:
  + Physician Assistant
  + Private Duty Nurse
  + Physical Therapist
  + Speech Language Pathologist
  + Acupuncturist
  + Allied Dental Professional
  + Certified Mental Health Rehab Prof-CPRP
  + Dentist
  + Hearing Aid Dispenser
  + Licensed Dietician or Licensed Nutritionist
  + Licensed Independent Clinical Social Worker
  + Nurse Midwife
  + Optometrist
* 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:

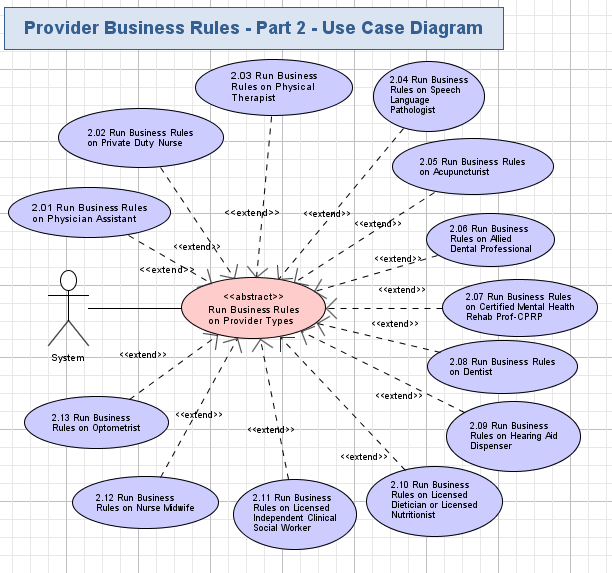
* The business processes, screening rules and workflows defined in this document expand on the conceptualization document from the previous Medicaid Provider Screening Portal Application contest. This document is for a component of the overall system described in that document, so overall system functionality 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 Physician Assistant

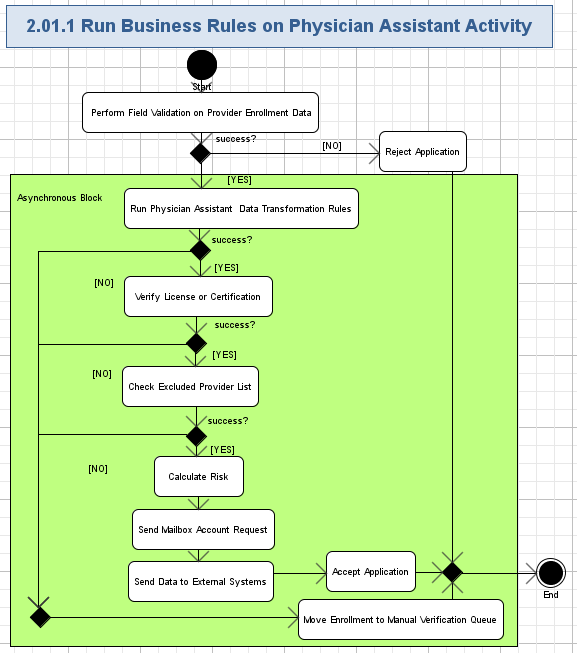
The system will run business rules on the “Physician Assistant” provider type (the type number is 69). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.6

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Physician\_Assistant\_.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 Assistant 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 (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 Physician Assistant 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 69 |
| 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 (Physician Assistants 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 | 03 |
| 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.  Physician Assistants are to receive the following programs: AC 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.  A Physician Assistant is to receive the following Categories of Service: 032, 034, 043, 046, 051, 053, 054, 058, 075, 076, 079, 080, 092, 117, 124  If the provider signed the 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 "21."  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. |
| RESTRICT | In the RESTRICT column, "A" is to indicate an active file.  "Y" is to indicate that the certification has been verified.  “T” is to indicate temporary license |
| **Exceptions** | |
| Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code 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 Assistant license in state of practice | This license is required. |
| 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 2.1.1.1.

#### 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 Private Duty Nurse

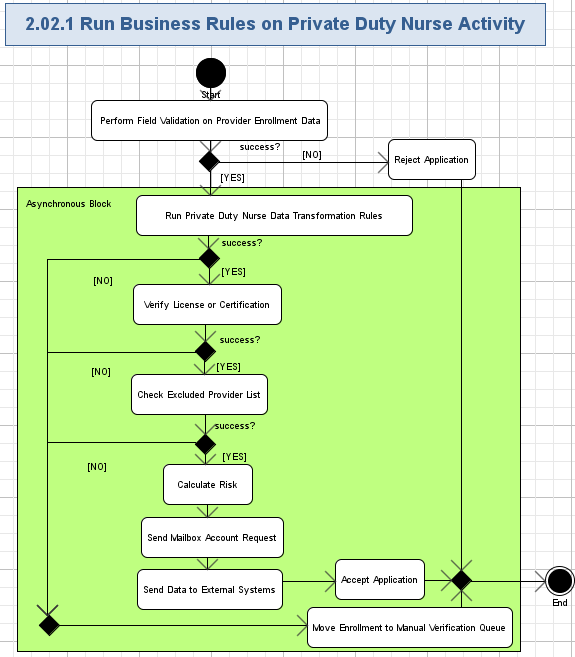
The system will run business rules on the “Private Duty Nurse” provider type (the type number is 64). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.7

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Private\_Duty\_Nurse\_.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 Private Duty Nurse 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 (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 Private Duty Nurse 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 64 |
| 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 (Physician Assistants 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. |
| Specialties | 1. for RNs 2. For LPNs. |
| 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 Private Duty Nurse is to receive the following programs: AC, BB, FF, JJ, KK, LL, MA, NM, 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.  Private Duty Nurse is to receive the following Categories of Service: 034, 043, 089, 092, 097 and 122  PDNs can NOT be given COS 038 and/or 119 because they must obtain a PCPO/PCA Choice provider id (provider type 38) by completing a separate application. |
| **PLIC** | |
| License Type | RN = 64 |
| RN License | Format: R123456-7 |
| BEGIN DATE | Begin date, required. |
| EXP DT | End date, required. |
| STATE | two-letter state abbreviation for the state of practice |
| RESTRICT | ‘A’ in the RESTRICT field to indicate an active file and ‘Y’ in the VERIFIED field to show that the license has been verified. |
| **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 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 license is required. |
| Private Duty Nurse Class A Home Care License from the MN Department of Health | This license is required. |
| Electronic Funds Transfer (EFT) request form | Required. |
| NPI | The NPI is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |
| Verify Licenses | Verify nurse licenses with Minnesota Board of Nursing of Nursing website : (www.hlb.state.mn.us/mbn/online/LicVerify/Verification.aspx)  Class A On Dept. of Health Website: (www.health.state.mn.us/divs/fpc/directory/providerselect.cfm) |

* 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Physical Therapist

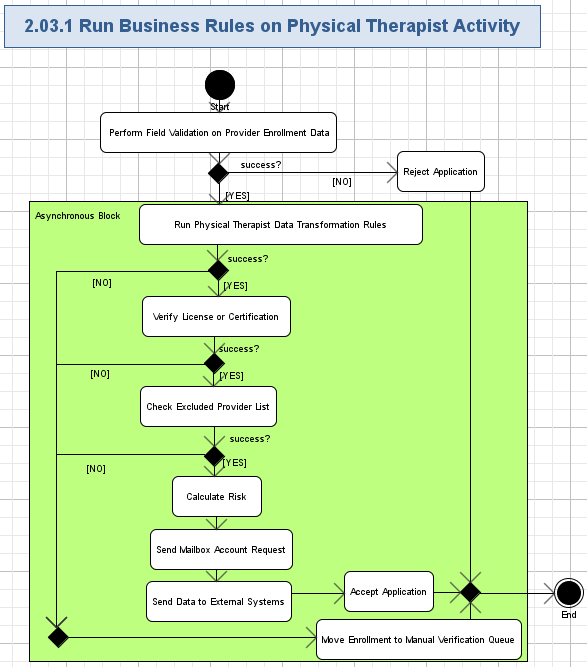
The system will run business rules on the “Physical Therapist” provider type (the type number is 39). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.7

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Physical\_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 Physical 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 (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 Physical 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 39 |
| 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 (Physician Assistants 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.  Physical Therapists are to receive the following programs: BB, EH, FF, GM, JJ, KK, LL, MA, NM, QM, RM, DM |
| Specialties | If provider is licensed by another state or by a reservation and working on a reservation, it should be an appropriate specialty code. |
| **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.  Physical Therapists are to receive the following Categories of Service: 043, 051, 054, 121 |
| **PLIC** | |
| license number | license number for the state of practice as shown on the copy of the license |
| TYPE | License type = 39 |
| BEGIN DATE | Begin date, required. |
| EXP DT | End date, required. |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Enrollment Criteria** | |
| Licensure | Licensure as a Physical Therapist in state of practice |
| Note | Only PT’s in private practice are eligible for MHCP enrollment. If the PT 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. |
| Physical Therapist License in the state of practice | This License 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 2.3.1.1.

#### 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Speech Language Pathologist

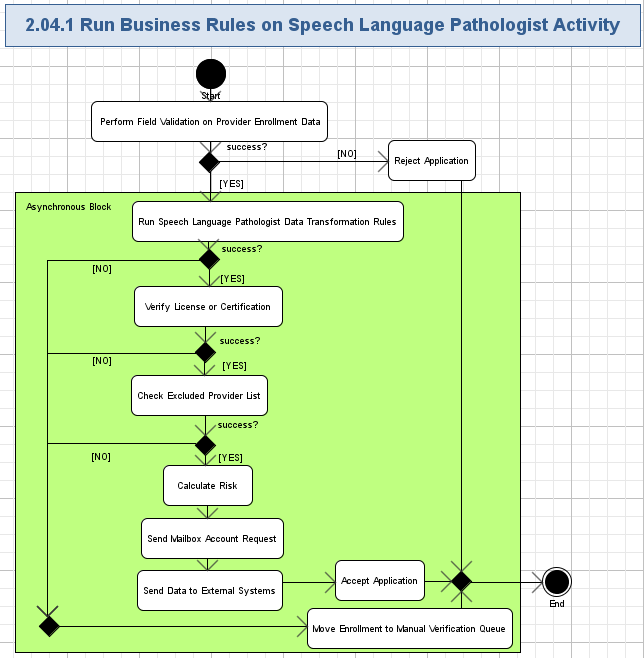
The system will run business rules on the “Speech Language Pathologist” provider type (the type number is 40). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.9

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Speech\_Language\_Pathologist\_.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 Speech Language Pathologist 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 (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 Speech Language Pathologist 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 40 |
| 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 (Physician Assistants 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 |
| **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.  Speech Language Pathologists are to receive the following programs: BB, FF, JJ, KK, LL, MA, NM, QM, RM, XX, EH, DM |
| Specialties | If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list. |
| **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.  Speech Language Pathologists are to receive the following Categories of Service: 043, 053, 058, 125 |
| **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. |
| Photocopies | Photocopies of the Provider’s ASHA certification and MDH registration are sufficient for verification. |
| ASHA certification account number | The ASHA certification account number should be entered as given on the application form, and later verified. ASHA account numbers are eight digits long. The begin date should be entered as given and the end date left open. TYPE is “40". Enter “XX” in STATE field to denote that the provider has been certified by the national board. |
| MDH registration number | The MDH registration number should be entered as above, except that the registration number is four digits, and “MN” is entered in the STATE field. |
| **Exceptions** | |
| Speech-language pathologists | Speech-language pathologists must maintain office space and equipment at their own expense. If it is indicated on the application that the applicant does not maintain office space/equipment, the application must be denied.  Alternatively, the practitioner can enroll if they are an employee of one of the following health care providers:  Federally Qualified Health Center  Indian Health Service  Nursing facility  Outpatient hospital  Physician clinic  Rehabilitative agency  Rural Health Center |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Other Information** | |
| Speech pathologists | Speech pathologists that are completing their clinical fellowship year may provide services under the supervision of an enrolled speech pathologist; however they may not be independently enrolled. These services are paid at the same rate as services delivered by the speech pathologist, so no modifier is needed on the claim. |
| Credentials | Credentials to show after therapist’s name MA (or PhD, etc) CCC SLP |

#### 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. |
| Certification as Speech Language Pathologist by the American Speech-Language Hearing Association (ASHA) | This is required. |
|  |  |
| Registration with MN Department of Health (MDH) | This is required. |
| Maintain office | Maintain office space at own expense, must be working independently |
| 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Acupuncturist

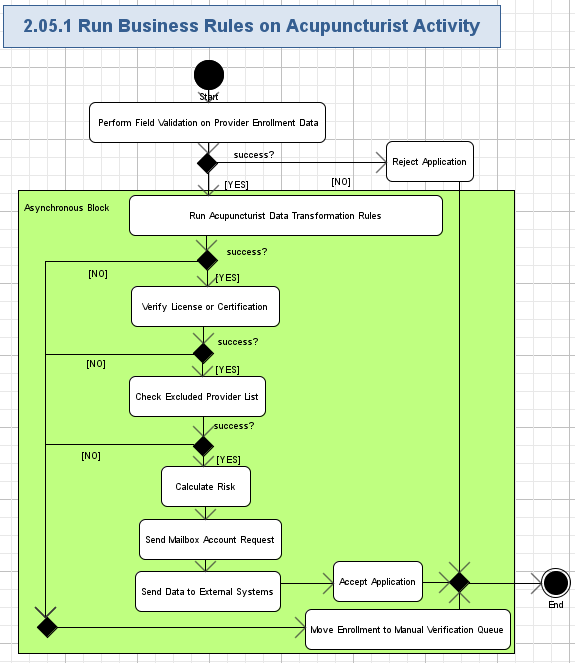
The system will run business rules on the “Acupuncturist” provider type (the type number is AP). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 2: 3.1.1 and 3.1.10

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Acupuncturist \_.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 Acupuncturist 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 (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 Acupuncturist 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = AP |
| 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 (Physician Assistants 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.  Acupuncturists 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.  Acupuncturists are to receive the following Categories of Service: 043 |
| **PLIC** | |
| license number | license number for the state of practice as shown on the copy of the license or certificate  (License) 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 | AP |
| Begin Date | The begin date, required. |
| EXP Date | The end date, required. |
| **PGRP** | |
| BEGIN DT | The begin date usually should be the same effective date entered on the PADD screen. |
| END DT | Blank. |
| NPI | The group’s NPI or UMPI. |
| Group practice Member | If the application is for a member of a group practice, and the group practice is enrolled, the individual should be affiliated with that group practice NPI or UMPI. Enter all affiliations appearing on the application. Often, the applicant will forget to consider the practice listed at the practice address as an affiliation. Add that affiliation to the record. |
| **PROL** | |
| NPI | Provider’s NPI. 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 | Same effective date as the PADD screen. If that is a future date, enter today’s date |
| END DATE | Blank. |
| ROLLED UP | The indicator for individuals is always N. |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Other Information** | |
| Providers | Providers that are dual licensed as Acupuncturists and Chiropractors will be enrolled as Chiropractors. Add specialty code AP to the PPGM screen, and add their license #, effective date, and expiration date to PLIC. License Type AP. |

#### 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. |
| Acupuncturist License in the state of practice | This License 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 2.5.1.1.

#### 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Allied Dental Professional

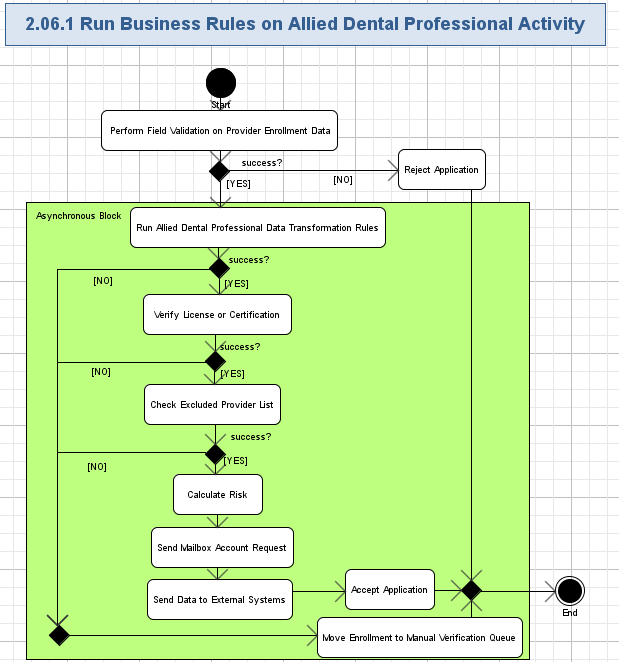
The system will run business rules on the “Allied Dental Professional” provider type (the type number is 31). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.2

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Allied\_Dental\_Professional\_.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 Allied Dental Professional 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Allied Dental Professional 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 | 01 for Individual, 06 for Dental Hygienist Clinics |
| 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 (Physician Assistants 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 | 3 (Non-pay to) for Individuals, 1 for Clinics. |
| 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.  Allied Dental Professionals are to receive the following programs: FF GM HH 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.  Allied Dental Professionals are to receive the following Categories of Service: 043, 045.  NOTE: Clinics do not receive COS |
| **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. |
| PSUR | |
| Enhanced Service Codes | 11 = Collaborative Hygienist  12 = Dental Therapist  13 = Advanced Dental Therapist |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Other Information** | |
| MN Board of Behavioral Health and Therapy | 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. |
| Dental hygienist license | This license is required. |
| Collaborative Practice Dental Hygienist Assurance Statement (DHS-6025) | Required |
| Copy of collaborative agreement that meets the requirements of Minn. Stat. Section 150.10, Subd.(2)(c) and (e) (individuals) | Required |
| Copy of license of dentist who signed collaborative agreement | Required |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |
| Licenses/Certifications | Employed by one of the following enrolled groups:  Health Care Facility  Program (such as Head Start)  Non-profit Organization |

* 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Certified Mental Health Rehab Prof-CPRP

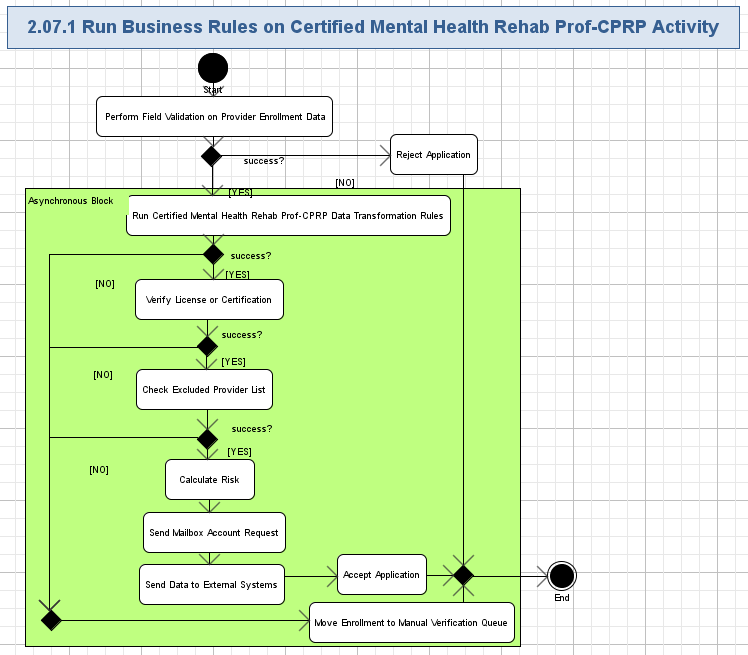
The system will run business rules on the “Certified Mental Health Rehab Prof-CPRP” provider type (the type number is 26). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.3

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Certified\_Mental\_Health\_Rehab\_Prof-CPRP\_.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 Mental Health Rehab Prof-CPRP 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Certified Mental Health Rehab Prof-CPRP 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 26. |
| 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 (Physician Assistants 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.  Mental Health Rehabilitation Specialist are to receive the following programs: BB, FF, GM, IM, LL, MA, NM, EH, DM, KK |
| **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.  Mental Health Rehabilitation Specialists are to receive the following Categories of Service: 043, 046 |
| **PLIC** | |
| license number | As stated on the license verification letter. |
| BEGIN DT | As stated. |
| EXP DT | Left to default. |
| Type | 26 |
| STATE | Abbreviation of state in which license was granted. |
| VER LTR | Skip |
| BOARD | Skip |
| RESTRICT | A to indicate an active file or "N" to indicate that the license has not been verified. |
| **PGRP** | |
| BEGIN DT | The begin date for GROUP MEMBERSHIP usually should be the same effective date entered on the PADD screen. |
| END DATE | Leave open. |
| GROUP NBR | Group number of the practice the provider is affiliated. The group’s MA provider number should be entered |
| Group practice Member | If the application is for a member of a group practice, and the group practice is enrolled, the individual should be affiliated with that group practice NPI or UMPI. Enter all affiliations appearing on the application. Often, the applicant will forget to consider the practice listed at the practice address as an affiliation. Add that affiliation to the record. |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Enrollment Criteria** | |
| Individual | Individual must be a Mental Health Rehabilitation Specialist under Minnesota Statutes, sections 245.462, subd. 18, clause (6) and hold a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner and who is employed by a certified Adult Rehabilitative Mental Health Services (ARMHS) provider entity. |
| New applicants | New applicants must be approved by Adult Mental Health Division (current system must be approved by Richard Seurer). |

#### 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. |
| Valid national certification as a certified rehabilitation counselor or Certified psychosocial rehabilitation practitioner | This is required. |
| Signed Assurance Statement (DHS-6095 - Certified Mental Health Rehabilitation Professional Assurance Statement) | This is required. |
| Copy of Masters in a related field | 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 Dentist

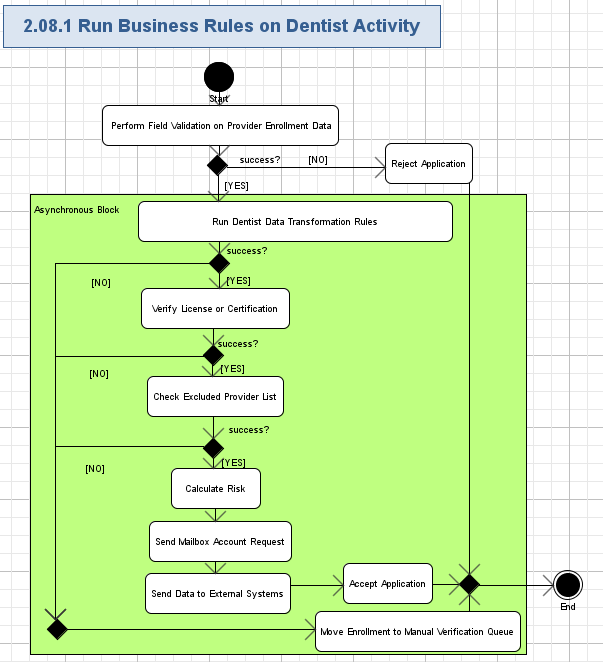
The system will run business rules on the “Dentist” provider type (the type number is 30). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.4

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Dentist\_.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 Dentist 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Dentist 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 30 |
| 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 (Physician Assistants 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 | 62 = General Dentistry  ED = Endodontist  61 = Oral Surgery (requires copy of Oral Surgery certification)  63 = Orthodontics  64 = Pedodntics  65 = Periodontics  73 = Prosthodontics  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.  Dentists are to receive the following programs: BB FF GM HH 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.  Dentists are to receive the following Categories of Service: 043 045 |
| **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 "30" |
| PSUR | |
| Enhanced Service code | 01 if deemed a Critical Access Dental Provider. Some dental providers are determined to be a “critical access,” which allows them to receive an additional 40% payment over the current MHCP allowable. Mary Morales (431-3268) in the policy unit determines if the dental provider qualifies, and will notify PE of providers and their effective dates. PE will also be notified if a dental provider is no longer a critical access provider and an end date will need to be entered. |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Other Information** | |
| Dentists | Dentists with “Full Facility” licensure can also practice outside of the teaching facility as long as they are still employed 50 % time or more at the teaching facility. (Minnesota Dental Board determines this.) Dentists with “Limited Faculty” licensure can only practice at a teaching facility. |

#### 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. |
| Dental license | This is required. |
| NPI | This is required. |
| Individual Practitioner Enrollment Application (DHS-4016) | Required. |
| Oral Surgeon by ABOMS | If Oral Surgeon specialty indicated: dentists must be certified or registered as “board eligible” as an Oral Surgeon by ABOMS |

* 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Hearing Aid Dispenser

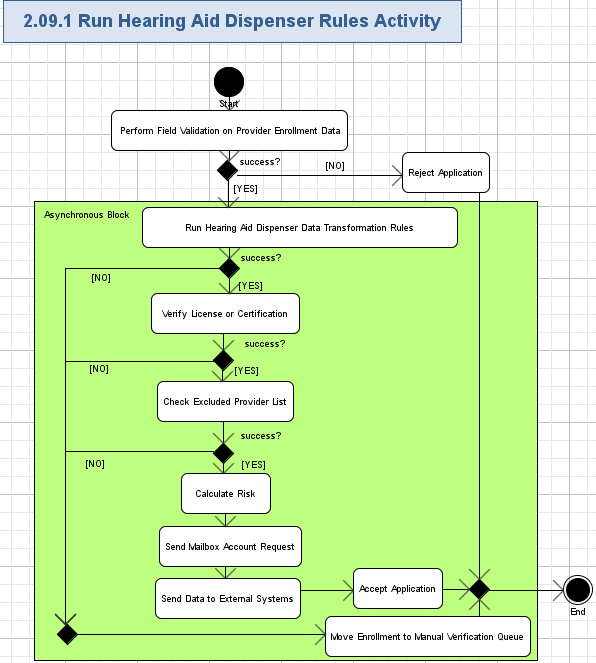
The system will run business rules on the “Hearing Aid Dispenser” provider type (the type number is 77). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.5

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Hearing\_Aid\_Dispenser\_.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 Hearing Aid Dispenser 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Hearing Aid Dispenser 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 77 |
| 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 (Physician Assistants 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” |
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| 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. |
| Specialties | If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list |
| 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 Hearing Aid Dispensers 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.  Hearing Aid Dispensers are to receive the following Categories of Service: 032, 043, 077 |
| **PLIC** | |
| license number | As stated on the roster and/or certificate copy. |
| Type | 77 |
| BEGIN DATE | Required |
| END DATE | Blank. |
| **PGRP** | |
| Group Membership | Group Membership – Physician Assistants may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | -The billing agents are required. |
| **Exceptions** | |
| Hearing Aid Dispensers | A number of Hearing Aid Dispensers currently enrolled in the MHCP are additionally qualified as Certified Audiologists. Relatively few are enrolled in MHCP as "Independent Audiologists" because most do not meet our criteria for "independent" status. (See Independent Audiologist enrollment criteria for explanation.) Since hearing aid dispensing is a service granted only to individual providers, all audiologist/dispensers who do not meet our criteria as "independent" still have to enroll as Hearing Aid Dispensers if they wish to be reimbursed for their dispensing services. |
| Hearing Aid Dispenser Trainees | Hearing Aid Dispenser Trainees are granted their own provider numbers and are given the same privileges as certified dispensers. They are supervised by certified dispensers, but the only difference is that trainees are given "end dates" on PLIC and PCOS screens. "Begin dates" and "end dates" are assigned according to the roster entitled "MN Hearing Aid Dispenser Trainees." Once a trainee becomes a fully certified dispenser, the individual must send in a copy of his/her dispense certificate. The end dates will then be removed from the individual’s provider number |
| Wisconsin applicants | The State of Wisconsin no longer issues a separate Hearing Instrument Specialist License to Audiologists licensed in Wisconsin (confirmed in 9/5/01 phone call [608-266-2112] with Lori at the Wisconsin Bureau of Health Professional Licensing). Wisconsin considers the dispensing of Hearing Aids to be “within the scope” of a certified/licensed Audiologist. For Wisconsin applicants who are not eligible for enrollment as an Audiologist, a copy of their Wisconsin Audiologist license is sufficient for enrollment as a MHCP Hearing Instrument Dispenser. |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice. |
| **Enrollment Criteria** | |
| Individuals | Individuals must have permit from the Minnesota Department of Health as a hearing instrument dispenser. Hearing aid dispensers who practice in Minnesota must have current certification through the MN Department of Health |
| providers | Out of state providers must hold a current Hearing Instrument Dispenser Certificate 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. |
| Copy of Hearing Instrument Dispenser Certificate | Required. |
| License certification from the Minnesota Department of Health or state of practice | 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Licensed Dietician or Licensed Nutritionist

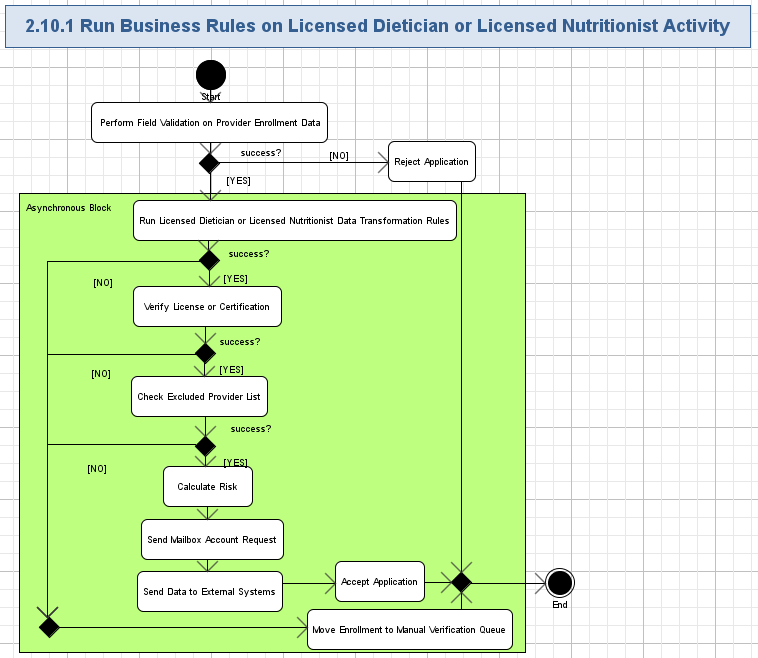
The system will run business rules on the “Licensed Dietician or Licensed Nutritionist” provider type (the type number is 15). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.6

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Licensed\_Dietician\_or\_Licensed\_Nutritionist\_.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 Dietician or Licensed Nutritionist 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Licensed Dietician or Licensed Nutritionist 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 15 |
| 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 (Physician Assistants 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 |
| 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 Dieticians or Licensed Nutritionists are to receive the following programs: AC BB FF GM IM JJ KK LL MA NM QM RM XX EH |
| **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 Dieticians or Licensed Nutritionists are to receive the following Categories of Service: 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 "15" |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code 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 | 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 2.10.1.1.

#### 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Licensed Independent Clinical Social Worker

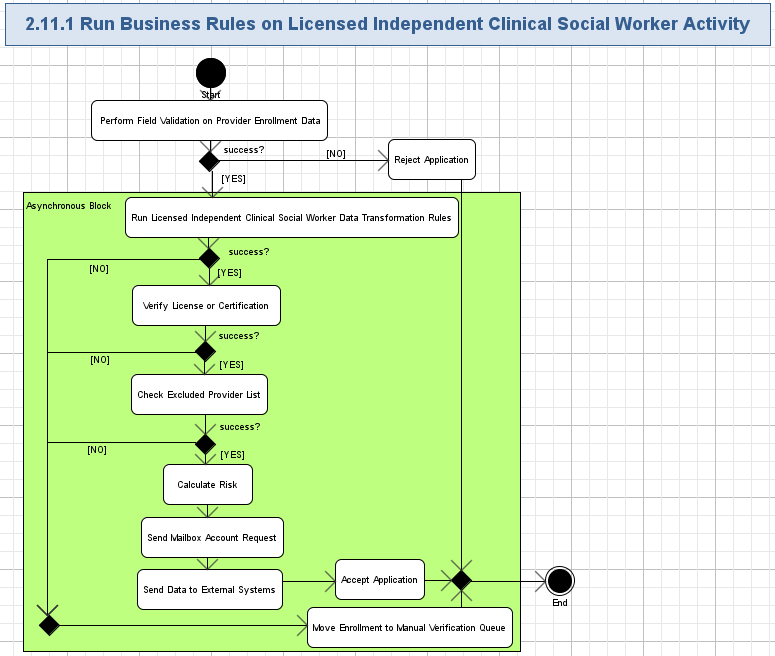
The system will run business rules on the “Licensed Independent Clinical Social Worker” provider type (the type number is 14). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.7

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Licensed\_Independent\_Clinical\_Social\_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 Licensed Independent Clinical Social 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 |
| 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Licensed Independent Clinical Social 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 14 |
| 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 (Physician Assistants 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 |
| **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 Dieticians or Licensed Nutritionists are to receive the following programs: BB EH FF GM HH IM JJ KK LL MA NM QM RM XX DM |
| specialties | QS = For Psych Specialty providers who signed a Qualified Mental Health Supervision AAS (DHS-6330)  BT = Providers who are approved as Dialectical Behavioral Therapists. PE is notified from Julie Pearson or Carol LaBine of approved providers and their effective dates. |
| **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 Dieticians or Licensed Nutritionists 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 "14." |
| **Exceptions** | |
| Dual licensed providers | A number of mental health providers are licensed from multiple boards. Providers who are licensed as an LICSW and an LMFT, or LPCC are enrolled with MHCP as LICSWs. Add COS 117 if also LMFT. |
| Providers | Providers who are also licensed Psychologists are enrolled as an LP. |
| 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 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 | To be considered as an LICSW in the MN Medicaid program, the provider has to meet the same requirements set for MN LICSWs:  The provider must have a Masters in Social Work (MSW).  The provider must be licensed as an Independent Clinical Social Worker, or an equivalent that satisfies Minnesota’s statutory license requirements.  North Dakota = LICSW  South Dakota = CSW (Clinical Social Worker)  WI = LCSW (Licensed Clinical Social Worker)  IA = ISW (Independent Social Worker). |

#### 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 is required. |
| NPI | Required |
| Individual Practitioner Enrollment Application (DHS-4016) | 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 2.11.1.1.

#### 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Nurse Midwife

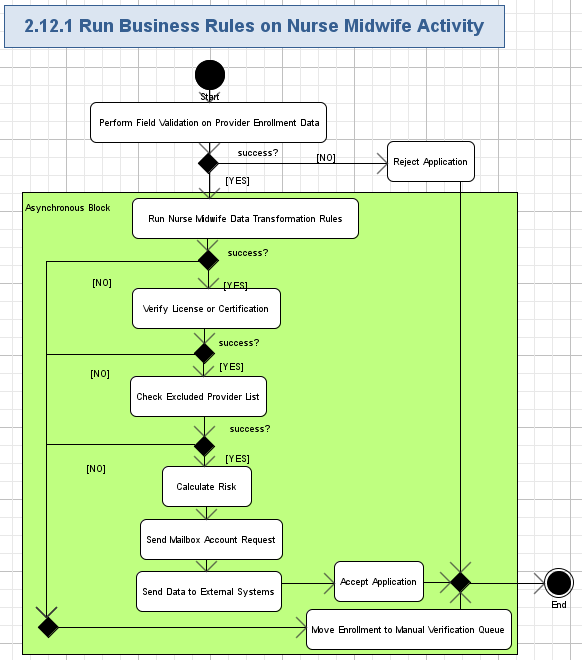
The system will run business rules on the “Nurse Midwife” provider type (the type number is 66). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.8

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Nurse\_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 Nurse 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 |
| 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Nurse 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 66  This provider type can be a group, but must be composed of at least two enrolled Certified Nurse Midwives. |
| 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 (Physician Assistants 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.  A Nurse Midwife is to receive the following programs: BB FF GM IM JJ KK LL MA NM QM RM XX EH FP DM |
| Specialties | If provider is licensed by another state or by a reservation and working on a reservation, enter appropriate specialty code from the list |
| **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 Midwife is to receive the following Categories of Service: 032, 043, 079, 080, 090  If provider signed Child & Teen Checkup Agreement (DHS-4646):  Add: 040, 058 |
| **PLIC** | |
| license number | MN RN license in the following format: R123456-7 |
| License type | RN=64, CNM=66 |
| **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 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. See exceptions for Nurse Licensure Compact information | This is required. |
| Nurse Midwife Certification from the American Midwifery Certification 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

## Run Business Rules on Optometrist

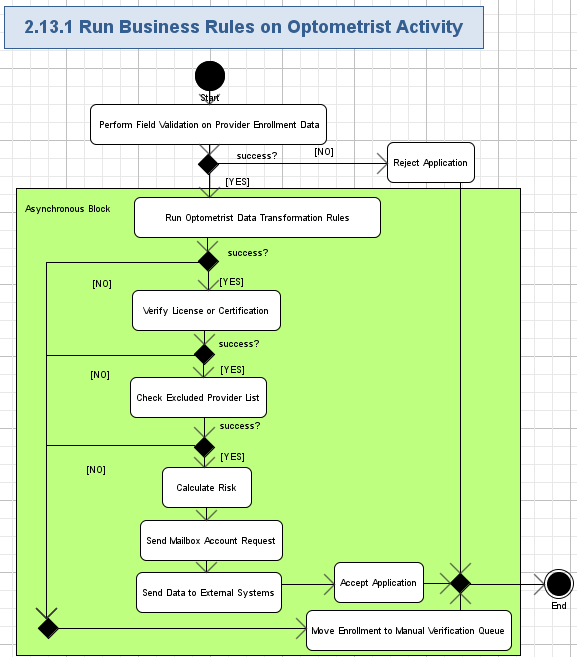
The system will run business rules on the “Optometrist” provider type (the type number is 35). The business rules will include validation rules and screen rules. The validation rules and the screening rules will be explained.

Conceptualization Reference: Screening Rules for Selected Provider Types – Part 3: 3.1.1 and 3.1.9

Wireframe reference: New\_Enrollment\_-\_No\_Payment\_\_Optometrist\_.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 Optometrist 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 |
| **Mailing(Group Affiliation Information)** | | | |
| Group Name | The name of the group. | String, 100 chars, non empty. | Y |
| Group NPI / UMPI | The NPI/UMPI of the group. | String, 100 chars, non empty. | Y |
| Practice Location Address | The address of the practice. | 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 Optometrist 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 LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS CLINIC |
| SORT NAME | This field contains Name of company  Example: MINNESOTA LAKES LICENSED INDEPENDENT CLINICAL SOCIAL WORKERS 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,  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 = 35 |
| 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 (Physician Assistants 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 |
| providers’ date of birth | Required. Format: mm/dd/yy |
| providers’ NPI number/Effective Date | Required. |
| **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 |
| 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.  Optometrists 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.  Optometrists are to receive the following Categories of Service: 032, 043, 075, 076, 078 and 079  NOTE: Optometrists can NOT receive COS 040 |
| **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 "35."  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 – Physician Assistants may have group memberships. Enter the appropriate individual’s employer’s NPI. |
| Billing Agents | The billing agents are required. |
| **Exceptions** | |
| Providers | Providers at a Public Health Service (PHS) Indian Hospital may have current licensure from any state. Add appropriate Tribal Code to the Specialties. Provider cannot be affiliated with non-Tribal organization until licensed in the state of practice |
| **Other Information** | |
| PROV | Check PADD screen for PROV. NOTES IND (Y/N). If "Y" is indicated, read the text listed under this provider's number. Check to see if this provider's license has been revoked or suspended by the Board of Optometry. Check to see if this provider's license has been revoked or suspended by the Board of Optometry |
| **Enrollment Criteria** | |
| Individual | Individual must be licensed as an optometrist under Minnesota Statutes, sections 148.52 through 148.62 or, if out of state provider, pursuant to the licensing requirements of the relevant jurisdiction. Minnesota optometrists can be verified by visiting the online verification system. The licensing of out of state optometrists should be verified by visiting the out of state website or by sending a letter to the appropriate licensing agency or medical assistance agency. |

#### 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. |
| Verified Optometrist License | This License 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.

#### Accept Application

* The system will accept the application (for further processing) if the field validation and screening validation are both successful.

# 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+2>

### 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 Physician Assistant | X |
| 2.2 Run Business Rules on Private Duty Nurse | X |
| 2.3 Run Business Rules on Physical Therapist | X |
| 2.4 Run Business Rules on Speech Language Pathologist | X |
| 2.5 Run Business Rules on Acupuncturist | X |
| 2.6 Run Business Rules on Allied Dental Professional | X |
| 2.7 Run Business Rules on Certified Mental Health Rehab Prof-CPRP | X |
| 2.8 Run Business Rules on Dentist | X |
| 2.9 Run Business Rules on Hearing Aid Dispenser | X |
| 2.10 Run Business Rules on Licensed Dietician or Licensed Nutritionist | X |
| 2.11 Run Business Rules on Licensed Independent Clinical Social Worker | X |
| 2.12 Run Business Rules on Nurse Midwife | X |
| 2.13 Run Business Rules on Optometrist | 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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