

Section 1 – Participating Provider Application Process

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Participating Provider Application Process

Health care providers often find that in order to receive the best reimbursement, or any at all, with the least cost-sharing for their patients, a participating agreement must be entered into with health coverage plans, public or private. These agreements can be in many forms – a contract, a memorandum of understanding (MOU) or an enrollment.

Traditionally, a payer establishes a network by promising the provider it will utilize the benefit of lower cost-sharing (waiving deductibles or copays and paying 100% of the allowed charge) to drive members to seek care from a network provider. In return, the provider agrees to a negotiated fee that is often less than their full charge. To build in exclusivity, the payers have policies in place to limit their networks, by line of business, to a specific number of different types of providers within a geographic area. Network recruiters base their strategies on type of providers required and on number of members served in that area or by employer and/or member request for a provider.

Local health departments in a county with few immunization providers may have an easier time obtaining a favorable agreement with a payer than a LHD in an area densely populated with primary care providers. This is simply because the payer doesn't need the LHD in its network. The LHD must then make a case for why they should be included in a network.

Each payer has a different approach to recruiting providers. If the LHD isn't being recruited to join a network, they must then follow the payer's specific process. General initial processes are similar and outlined below.

Key Concepts:

National Provider Identifier (NPI)
Preparation & enrollment processes
Commercial health plan
Medicare
Medicaid

All Plan Types

In order to submit claims for any plan type, you must have a National Provider Identifier (NPI).

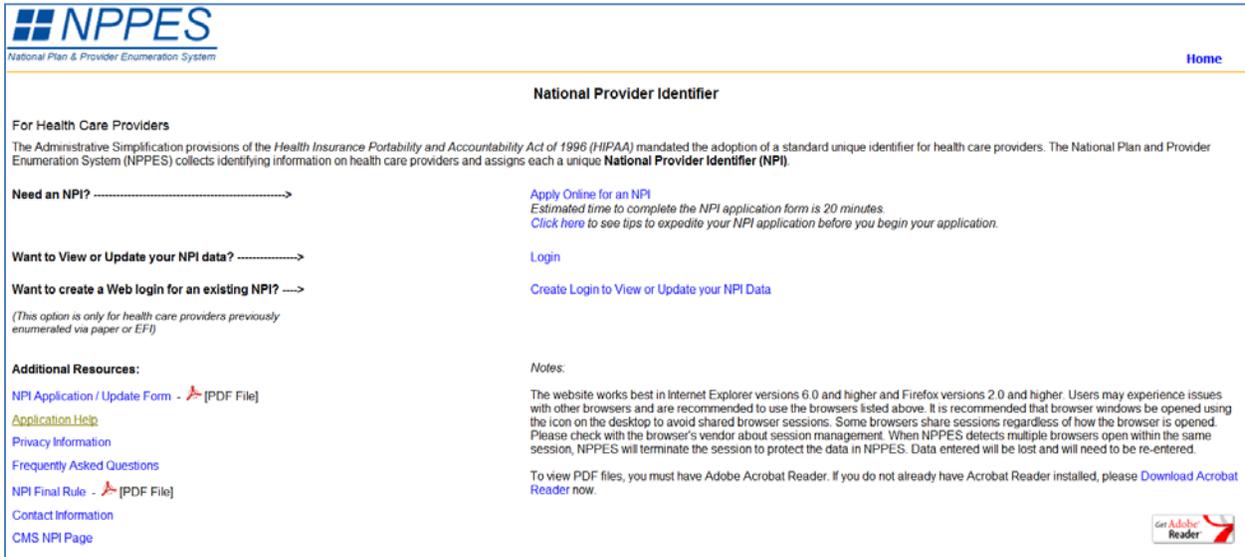
1. Go to the National Plan & Provider Enumeration System (NPPES) webpage at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.
2. Look for the following link in the middle of the page:

If you are a **Health Care Provider**, you must click on **National Provider Identifier (NPI)** to login or apply for an NPI.

3. The next page will allow you to apply for the NPI, create a webpage account, review help and FAQ documents, etc. There are two types of NPI entity codes.

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- a) Entity Type Code 1 (A Person) – Individuals who render health care or furnish health care supplies to patients; e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists.
 - b) Entity Type Code 2 (A Non-Person) – Organizations other than an individual that render health care services or furnish health care supplies to patients; e.g., hospitals, home health agencies, ambulance companies, health maintenance organizations, durable medical equipment suppliers, pharmacies, group practices.
4. LHDs should apply for Entity Type 2.
 5. Some organizations prefer to have a dedicated NPI for use in billing different programs – such as one for immunizations. This can make payment reconciliation easier, but a separate one is not required.



6. The following information will be required and should be available. If all the information is available, entry should take approximately 20 minutes to obtain the NPI.

Information Required for Individual Providers	Information Required for Organizations
Provider Name	Organization Name
SSN (or ITIN if not eligible for SSN)	Employer Identification Number (EIN)
Provider Date of Birth	Name of Authorized Official for the Organization
Country of Birth	Phone Number of Authorized Official for the Organization
State of Birth (if Country of Birth is U.S.)	Organization Mailing Address
Provider Gender	Practice Location Address and Phone Number
Mailing Address	Taxonomy (Provider Type)
Practice Location Address and Phone Number	Contact Person Name
Taxonomy (Provider Type)	Contact Person Phone Number and E-mail
State License Information	
Contact Person Name	
Contact Person Phone Number and E-mail	

7. See **Appendix 1** for a sample of a LHD NPI record.

Commercial Health Plans

It is best to start with the major payers located in your city/county. In Wisconsin, most employer based health coverage is provided by HMO's or other managed care plans. The Wisconsin Office of the Commissioner of

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Insurance (OCI) maintains a list of managed care organizations by county at: http://www.oci.wi.gov/hmo_info.htm#by_cnty .

Preparation

The following is a high-level process, regardless of the payer:

- 1) Locate the website for the payer you are interested in and find their provider or contracting page. If there is not an obvious link, try using keywords such as “provider relations”, “provider services”, “network”, “contract” to find the correct page. The following is an example from the Gundersen Health Plan website (**Figure 1**) – the homepage has a *Providers* tab which lists the general phone numbers and email address for provider representatives:



Figure 1 - Sample Health Plan Provider Page

- 2) The payer’s provider page should outline the contact process and/or provide a link to the form they prefer you to contact them. In this case, Gundersen has a link (see star on **Figure 1**) called *Join the Network*. If you click on that link, it will bring you to a new page of the same name.
- 3) (**Figure 2**) has a hyperlink to an online form you need to complete and return by email:



Figure 2 - Sample Health Plan Provider Participation Page

- 4) To find more detailed and/or specific information on contracting and/or the credentialing process, it is a good idea to locate the provider manual(s) for the line(s) of business in which you are interested – most payers have different versions by line of business (LOB). Again using Gundersen Health Plan, they have three separate manuals (**Figure 3**):

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GUNDERSEN HEALTH PLAN

SEARCH [Search] [Go]

Home | Print | Email | Bookmark | Site Map | TEXT SIZE A+ A-

Medicare Options Members Providers Employers & Brokers Forms About Us

▼ Providers

- Provider Directory
- Join the Network
- Provider Portal
- Hot Topics & News Flash Bulletins
- Provider Forms
- Prior Authorization and Referral
- Senior Preferred Part B Therapies
- Pharmacy
- Clinical Practice Guidelines
- Case & Disease Management
- Provider Connection Newsletter
- **Provider Manuals**
- Provider Standards
- ACH and 835 Provider Guide

Healthcare Providers

Home / Providers / Provider Manuals

Provider Manuals

Please select one of the following Provider Manuals to view policies, procedures and guidelines required by Gundersen Health Plan.

Commercial Provider Manual ★

This manual is designed specifically for Gundersen Health Plan Providers and is used to supply specific information needed for billing administration, care and treatment of Gundersen Health Plan members. This is a very dynamic informational tool that is updated regularly to give you the very latest information regarding policies, procedures and guidelines required by the Health Plan.

Senior Preferred Provider Manual ★

This manual is designed specifically for Gundersen Health Plan Senior Preferred Providers and is used to supply specific information needed for billing administration, care and treatment of Gundersen Health Plan members. This is a very dynamic informational tool that is updated regularly to give you the very latest information regarding policies, procedures and guidelines required by the Health Plan.

BadgerCare Plus Provider Manual ★

This manual is designed specifically for Gundersen Health Plan BadgerCare Plus Providers and is used to supply specific information needed for billing administration, care and treatment of Gundersen Health Plan members. This is a very dynamic informational tool that is updated regularly to give you the very latest information regarding policies, procedures and guidelines required by the Health Plan.

Any questions or concerns regarding these manuals may be directed to Provider Network Management at (800) 362-9567 ext. 58026 or ext. 58034 or (608) 775-8026 or (608) 775-8034.

Figure 3 - Sample Health Plan Provider Manual Page

Enrollment

- 1) In other cases, a payer may just require the submission of a *letter of intent* (**Appendix 2**) to begin the process. Here is an example (**Figure 4**) from the Arise Health Plan provider manual.

SECTION 35: PROVIDER CONTRACTING

Non-Contracted Providers

If interested in participating, please send a letter of intent to:

Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625

Please include the following information:

- Your name and address
- The services you provide
- If you provide any unique services or treatments
- All participating doctors at your location
- If you are treating any of our existing members

Figure 4 - Sample Health Plan Letter of Intent Data

- 2) If no direction is given, a letter of intent should include the following types of information:
 - a) LHD official name, address
 - b) Contact name, email and phone number
 - c) Names of professionals to be considered for credentialing (MD, DO, ANP, PA, etc.)
 - d) Tax Identification Number (TIN)
 - e) National Provider ID (NPI)
 - f) Explanation of LHD role and request to be considered an “immunization provider”

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- g) List of immunizations that you want to submit under commercial health plan(s)

A sample letter of intent is found in **Appendix 2**.

- 3) A few WI payers utilize the CAQH Universal Provider Datasource (UPD) as a repository of contract and credentialing data. It is available for the following types of providers:
 - a) Advanced practice nurse practitioner
 - b) Doctor of osteopathic medicine
 - c) Medical doctor

- 4) If you have a current record in the UPD, you need to supply your ID to the requesting payer. This will avoid having to gather and submit all the paperwork. If you do not have a record, the payer will give you an ID number, and you need to complete entry of the data (see **Appendix 3**). Users have estimated that it can take about two hours to complete a record if all information is available at the time of entry. CAQH recommends having the following information available:
 - a) CAQH-supplied Provider ID number
 - b) Basic Personal Information, including Social Security Number
 - c) Curriculum Vitae which includes
 - i) Address and contact information
 - ii) Education and Training
 - iii) Medical/Professional school
 - iv) Graduate school
 - v) Internships and residencies
 - vi) Fellowships and preceptorships
 - vii) Teaching appointments
 - d) Specialties and Board Certification
 - e) Practice Location Information, including list of all previous practice locations
 - f) Practice name and type
 - g) Practice address and contact information
 - h) Billing, office manager and credentialing contact
 - i) Services, certifications, limitations and hours of operation
 - j) Partners and covering colleagues
 - k) Hospital Affiliation Information
 - l) Malpractice Insurance Information
 - m) Work History and References
 - n) Disclosure and Malpractice History
 - o) IRS Form W-9(s)
 - p) Drug Enforcement Administration (DEA) Certificate
 - q) Controlled and Dangerous Substances (CDS) Certificate
 - r) State medical license(s)
 - s) Identification numbers (NPI, Medicare, Medicaid)
 - t) Malpractice insurance policy face sheet(s)
 - u) Summary of any pending or settled malpractice cases

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- 5) If the payer requires a completed form (hard copy or web-based), the following is standard information that will be requested (submission of document copies) and/or you need to provide identifiers (such as license number) so they can perform primary verification:
- a) Required Documents for Submission**
- i) The current and complete credentialing application
 - ii) W-9 form (available at <http://www.irs.gov/pub/irs-pdf/fw9.pdf>)
 - iii) Current, valid, and unrestricted, and non-probationary medical license with appropriate state licensing agency
 - iv) Copy of current, valid, unrestricted Valid Drug Enforcement Agency (DEA)
 - v) Copy of current, valid, unrestricted or Controlled Dangerous Substance (CDS) certificate, if required by the state & applicable to his/her specialty.
 - vi) Face sheet copy of malpractice insurance certificate.
 - vii) Face sheet copy of general liability insurance certificate.
 - viii) Full documentation of education and training
 - ix) Full documentation of work history
 - x) Full documentation of prior sanctioning activities by regulatory bodies and by CMS
 - xi) Full documentation of malpractice claims history
 - xii) A defined number of the most frequently billed codes with fees with copy of encounter or Superbill form used.
 - xiii) Signed attestation &/or release of information authorization form
 - xiv) Signed attestation &/or release of information authorization form
- b) Requirements to be Verified and/or Reviewed**
- i) Current, valid, and unrestricted, and non-probationary medical license with appropriate state licensing agency
 - ii) Professional liability insurance coverage, on a per occurrence basis, in the amount of **\$X00,000**, and **\$X,000,000** in the aggregate. [WIS. STAT. § 655.23 requires mandatory coverage of at least \$1 million per occurrence and \$3 million in the aggregate per year. Minimum levels are required for physicians to be licensed in the state.]
 - iii) Current Medicare and Wisconsin Medicaid certification
 - iv) Acceptable malpractice liability claims history
 - v) Prior sanctioning activities by regulatory bodies and by CMS
 - vi) Demonstrates lack of physical or mental impairment, including chemical dependency, that may impair the provider's ability to practice or may pose a risk of harm to patients
 - vii) Must not be currently debarred or excluded from participation Medicare, Medicaid or Federal Employees Health Benefits (FEHB).
 - viii) At the time of initial application, the practitioner must not have any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body
 - ix) Must be board certified in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement
 - x) Successful completion of a residency or fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).
 - xi) If not board certified, or have not completed a residency, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.

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- xii) The healthcare professional/provider's primary office location must be located within the service area or within the approved counties contiguous to the service area.
- 6) Follow-up with the provider network relations staff – the process can take from 30 to 180 days, depending on the payer, how complete your submission was and their understanding of LHD's:
 - a) Verify they received your *letter of intent* or application form.
 - b) Make sure the representative understands that this request is from a LHD and that you fully explain any missing data (such as hospital privileges, board certification, 24/7 coverage, etc.) and why it doesn't apply to immunization services.
 - c) Ask them to describe their process and timeline, so you know when to expect a decision.
 - d) Make sure to **get a name, email address, and phone number**. You will want to follow-up if a delay occurs in the timeline.
 - 7) There may be a credentialing requirement for your medical director or any *advanced* healthcare provider who will be administering immunizations. Nurses (RN, LPN) without advanced degrees/certification are generally not required to be credentialed. This can delay the agreement process. **See Section 2 - Participating Provider Agreements - Credentialing** for specific information.
 - 8) If the payer declines your request, you should ask for a full explanation and a copy of the appeal process, if it isn't available on their webpage or in their provider manual. The denial may be due to a business decision or due to the payer not understanding LHD's and their functions, and may need education.
 - 9) If you are successful and the payer wants to discuss a contract – congratulations! **See Section 2 - Participating Provider Agreements - Credentialing** for specific information.

Medicare

Providers that submit immunization claims for Medicare¹ beneficiaries must enroll in Medicare Part B. As required by section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS revised its claims processing contracts by *fiscal intermediaries* and *carriers* - with new contract entities called Medicare Administrative Contractors (MACs). Wisconsin Medicare Part B is transitioning from WPS (since 1966) to **National Government Services (NGS) effective September 7, 2013**.

Several decisions must be made before enrolling, the first of which is whether or not to become a participating provider. If you are enrolled in Medicare, but have not submitted the CMS-855 since November 2003, you will be required to submit a completed application.

All the *links* required for enrollment may be found at

http://www.ngsmedicare.com/wps/portal/ngsmedicare/EnrollmentTools?CONTRACTTYPE=Jurisdiction%2013%20Providers&LOB=Part%20B&utm_source=homepage&utm_medium=partb&utm_campaign=enrollment

¹ All information on Medicare enrollment found at CMS website <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>

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Preparation

Participation

Medicare payment on assigned claims is issued directly to the provider. There are two categories of physician provider types under Medicare:

Participating providers:

- agree to accept assignment;
- receive reimbursement directly from Medicare;
- agree to accept Medicare's full charge as payment in full and cannot balance bill the patient;
- are not subject to Medicare's limiting charge provision;
- may bill the patient for remaining Part B deductible, 20% coinsurance and non-covered charges; and
- do not have to submit Medigap claims since Medicare will automatically cross-over the claim to the secondary payer.

Non-participating providers:

- may accept assignment on a claim-by-claim basis;
- will see a 5% decrease in the approved charge for services under the Medicare fee schedule;
- are subject to Medicare's limiting charge provision; and
- cannot bill the patient for more than 115% of the approved charge on a non-assigned claim. If patient is under Minnesota Medicare, this is further limited to 100% of approved fee.

The following non-physician practitioners **are required to accept assignment** on all claims for their practitioner services:

- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Certified registered nurse anesthetists;
- Certified nurse midwives; and
- Registered dietitians/Nutrition professionals

A provider has 90 days, from your enrollment date, to decide to be a participating provider or supplier. The only other time a change in participation status can be made is during the open enrollment period, generally from mid-November through December 31.

Online Application Process

The next decision is whether to apply online or by submitting a paper application. Before either application can be completed, a number of other tasks are required, beginning with identifying the Authorizing Official (AO) of the provider or supplier organization. **NOTE: The pre-enrollment tasks may take several weeks to be completed.**

Authorized Official of the Provider or Supplier Organization:

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- 1) The AO of the provider or supplier organization will go to Internet-based Provider Enrollment, Chain and Ownership System (PECOS²). The AO must meet the regulatory definition found at 42 CFR § 424.502
 - a) *Authorized official* means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.
- 2) The AO will create a PECOS User ID and password as part of this registration process. **Note: User IDs and passwords are secure data and should not be shared.**
- 3) The AO will provide the requested information to CMS.
- 4) The CMS External User Services (EUS) Help Desk will verify the information.
- 5) If the AO is authenticated by the CMS EUS Help Desk, he or she will receive an e-mail notification to that effect from the CMS EUS Help Desk.

Note: The AO is also involved in approving the individual (or individuals) who will use Internet-based PECOS on behalf of the provider or supplier organization. Therefore, after the AO has been authenticated by the CMS EUS Help Desk, the AO should periodically check his or her e-mail to take the requested actions in PECOS I&A.

Individual Who Will Use Internet-based PECOS on Behalf of a Provider or Supplier Organization:

- 1) An individual who will use Internet-based PECOS on behalf of a provider or supplier organization will go to Internet-based PECOS at <https://pecos.cms.hhs.gov> to register in the PECOS Identification and Authentication system (PECOS I&A).
- 2) The individual will create a PECOS User ID and password as part of this registration process. **Note: User IDs and passwords are secure data and should not be shared.**
- 3) The individual will provide the requested information to CMS. This will include information about his or her employer and about the provider or supplier organization on whose behalf he or she would be submitting enrollment applications.
- 4) The individual will receive a system-generated e-mail indicating approval or disapproval of his or her request.
- 5) Once the individual's request for access is approved, he or she is considered a PECOS "user" and will submit enrollment application(s) on behalf of the provider or supplier organization.
- 6) If the Security Consent Form has not already been generated and approved, the user will download the Security Consent Form, ensure the form is completed, obtain the dated signature of the AO and the representative of the individual's employer (referred to as the "Employer Organization" in the Security Consent Form and who, by virtue of its representative.
- 7) The completed, signed, and dated Security Consent Form should then be mailed to the CMS EUS Help Desk.
- 8) If the Security Consent Form is approved by the CMS EUS Help Desk, the AO of the provider or supplier organization will receive an e-mail notification to that effect from the CMS EUS Help Desk³. **Note: The Security Consent Form cannot be approved if the AO of the provider or supplier organization is not already verified by PECOS I&A.**

² MLN document at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MEDEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf

³ External User Services (EUS) Help Desk at 1-866-484-8049 or EUSsupport@cgi.com.

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Note: The Security Consent Form is completed only one time to establish the relationship between the provider or supplier organization and the employer organization whose employee(s) would submit enrollment applications on behalf of the provider or supplier organization.

Enrollment

Online Process

Once the AO and the PECOS user(s) have completed the security process, the online application process can begin. The following are the basic steps to completing an enrollment action using Internet-based PECOS. Providers. At the bottom of the log-in page (**Figure 5**), there are several good video tutorials available.

- 1) Have an NPPES User ID and password to use Internet-based PECOS.
- 2) Go to Internet-based PECOS at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html>.

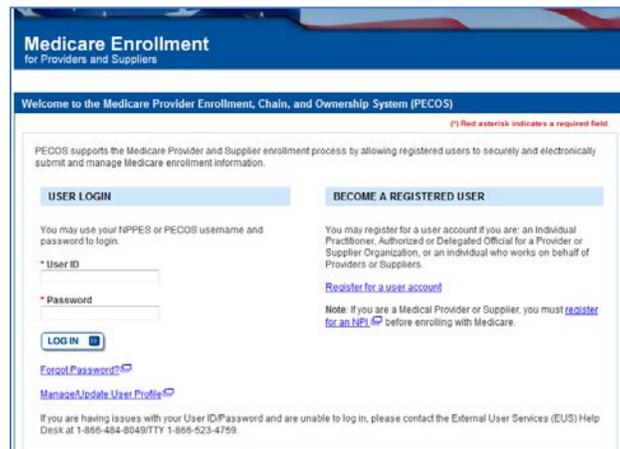


Figure 5 - Medicare Provider Enrollment PECOS Log-in Page

- 3) Complete, review, and submit the electronic enrollment application via Internet-based PECOS. (Note: Be sure to complete electronic funds transfer information when prompted to do so.)
- 4) Sign the application electronically:
 - a) CMS-855B Application is used by health care providers that will bill Medicare carriers. It can be found at - (<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf>).
 - i) The user completing the CMS-855B application is required to provide an e-mail address for the authorized signer(s) of the application as part of the submission process.
 - ii) Two system-generated e-mails will be sent to the authorized signer(s), who will then be required to follow the instructions in those e-mails to electronically sign the application.
- 5) The following are required supporting documents that must be submitted via mail or fax. The web application Tracking ID should be included on all supporting documents:
 - a) CMS-588 (Electronic Funds Transfer Authorization Agreement) located at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms588.pdf>
 - b) IRS CP575 (EIN letter). The CP575 is the notice the IRS issues when you are assigned an EIN. The IRS is unable to reissue or provide a copy of the CP575 notice.
 - i) If you lost your original notice and need confirmation of your EIN, you can call the IRS business help line at 1-800-829-4933, from 7am to 7pm.
 - (1) Tell them you cannot find your CP575 and would like a confirmation letter of your EIN.
 - (2) They will send out a 147C letter that may be used instead of the CP575 notice.

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- (3) This could take one to two weeks, so if you need it faster, ask to have it faxed.
- c) Copies of licenses and diplomas.

Paper Process

- 1) Submit the correct application.
 - a) The Medicare contractor that serves the provider's state or practice location is responsible for processing the NPI enrollment application. Effective 9/7/13, NGS is the Medicare Part B contractor for Wisconsin. A list of the Medicare fee-for-service contractors by state can be found in the download section of <http://www.cms.gov/MedicareProviderSupEnroll>.
- 2) Submit the 2008 version of the Medicare Enrollment Application (CMS-855).
 - a) Effective February 2008, CMS revised the CMS-855 Medicare enrollment applications. Providers and suppliers must submit the appropriate 2008 version of the CMS-855. The application version can be found in the lower left corner of the application. If an applicant submits an older version of the CMS-855, the Medicare contractor will return your application without further review. An electronic copy of the current CMS-855 Medicare enrollment application can be found at <http://www.cms.gov/CMSForms/CMSForms/list.asp>.
- 3) Submit a complete application.
 - a) When completing a CMS-855 for the first time for any reason, each section of an application must be completed in ink (blue preferable). When reporting a change to enrollment information, complete each section listed in Section 1B of the CMS-855.
 - b) Note: Providers that are enrolled in Medicare, but that have never submitted the CMS-855, are required to submit a complete application. Providers and suppliers should follow the instructions for completing an initial enrollment application.
- 4) Submit the Electronic Funds Transfer (EFT) Authorization Agreement with your enrollment application.
 - a) CMS requires that providers and suppliers, who are enrolling in the Medicare program or making a change in their enrollment data, receive payments via electronic funds transfer. When completing the CMS-588 form, complete each section. The CMS-588 form must be signed by the authorized official that signed the CMS-855.
 - b) Note: If a provider or supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required.
- 5) Submit all supporting documentation.
 - a) In addition to a complete application, each provider or supplier is required to submit all applicable supporting documentation at the time of filing. Supporting documentation includes:
 - b) Professional & business licenses,
 - c) NPI notification received from the NPPES,
 - d) Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588),
 - e) Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575
 - f) Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
 - g) Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
 - h) Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.
 - i) Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
 - j) Copy of an attestation for government entities and tribal organizations.
- 6) Sign and date the application.

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- a) Applications must be signed and dated by the appropriate individuals. Signatures must be original and in ink (blue preferable). Copied or stamped signatures will not be accepted.
- 7) Mail to MAC for Wisconsin:

National Government Services, Inc.
Attn: Provider Enrollment
P.O. Box 6475
Indianapolis, IN 46206-6475

Established providers may enroll, or terminate their participation, in the program only during Medicare's annual participation. New providers may file a participation agreement with a Medicare carrier at the time of initial enrollment or within 90 days after being enrolled.

To check the status of your application, you may do so by going to the NGS Provider Enrollment Status Inquiry Tool (**Figure 6** at: http://www.ngsmedicare.com/wps/portal/ngsmedicare/provider_enrollment

The screenshot shows a web form titled "Provider Enrollment Status Inquiry Tool". Below the title, it states: "This inquiry tool can be used to check on the status of your CMS-855 enrollment application." Under the heading "How to Search", it says: "To perform a search please enter into a field below either a valid case number (Option 1) or a valid National Provider Identifier (NPI) and Tax Identification Number (TIN) combination (Option 2)." The form is divided into two columns: "OPTION 1" and "OPTION 2". "OPTION 1" has a "Case Number" input field. "OPTION 2" has "NPI" and "TIN:" input fields. At the bottom of the form are "Submit" and "Clear" buttons.

Figure 6 - NGS Part B Provider Status Tool

Enrollment Fee

The fee for January 1, 2013, through December 31, 2013 is \$532.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

To pay the fee, go to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do> (**Figure 7**) and follow the instructions in the system:

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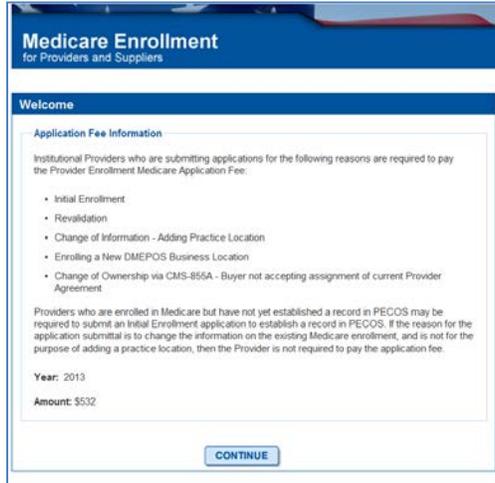


Figure 7 - Medicare PECOS Application Fee Payment Page

The following chart (**Figure 8**) indicates what provider types are required to pay the fee. It is assumed most LHD's would be applying as a mass immunization biller (using roster billing), which does require the fee.

<i>Application Fee requirements for Institutional Providers</i>	Enrollment Action				
	Initial Enrollment	Revalidation	Change of Ownership *	Change of Information other than Addition of Practice Location	Addition of Practice Location
Provider/Supplier Type					
Ambulance Service Supplier	Yes	Yes	No	No	Yes
Ambulatory Surgical Center	Yes	Yes	No	No	Yes
Clinic/Group Practice	No	No	No	No	No
Community Mental Health Center	Yes	Yes	No	No	Yes
Competitive Acquisition Program (CAP)/Part B Drug Vendor	Yes	Yes	No	No	Yes
Comprehensive Outpatient Rehabilitation Facility	Yes	Yes	No	No	Yes
Critical Access Hospital	Yes	Yes	No	No	Yes
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	Yes	Yes	No	No	Yes
End-Stage Renal Disease Facility	Yes	Yes	No	No	Yes
Federally Qualified Health Center	Yes	Yes	No	No	Yes
Histocompatibility Laboratory	Yes	Yes	No	No	Yes
Home Health Agency	Yes	Yes	No	No	Yes
Hospice	Yes	Yes	No	No	Yes
Hospital	Yes	Yes	No	No	Yes
Independent Clinical Laboratory	Yes	Yes	No	No	Yes
Independent Diagnostic Testing Facility	Yes	Yes	No	No	Yes
Indian Health Services Facility	Yes	Yes	No	No	Yes
Mammography Center	Yes	Yes	No	No	Yes
Mass Immunization (Roster Biller Only)	Yes	Yes	No	No	Yes
Non-Physician Practitioner	No	No	No	No	No
Organ Procurement Organization	Yes	Yes	No	No	Yes
Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services Provider that enroll via the CMS-855B	No	No	No	No	No
Physician	No	No	No	No	No
Portable X-ray Supplier	Yes	Yes	No	No	Yes
Radiation Therapy Center	Yes	Yes	No	No	Yes
Religious Non-Medical Health Care Institution	Yes	Yes	No	No	Yes
Rural Health Clinic	Yes	Yes	No	No	Yes
Skilled Nursing Facility	Yes	Yes	No	No	Yes

Figure 8 - Medicare Application Fee by Provider Type

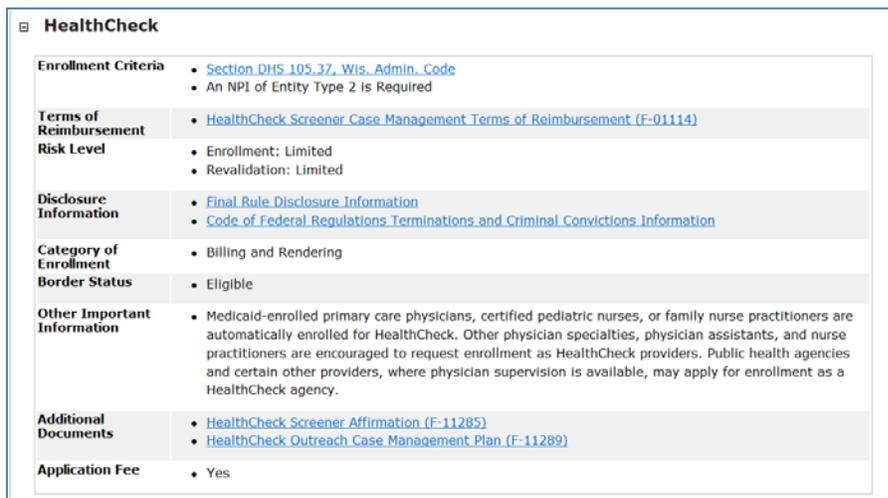
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Medicaid

In order to be reimbursed for immunization services⁴ provided to members enrolled in Wisconsin Medicaid, BadgerCare Plus, or SeniorCare programs, providers are required to be enrolled in Wisconsin Medicaid as described in [DHS 105](#), Wis. Admin. Code. Immunizations are covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. This program is called HealthCheck in Wisconsin.

Preparation

The ForwardHealth portal lists the following criteria for HealthCheck enrollment (**Figure 9**):



HealthCheck	
Enrollment Criteria	<ul style="list-style-type: none">• Section DHS 105.37, Wis. Admin. Code• An NPI of Entity Type 2 is Required
Terms of Reimbursement	<ul style="list-style-type: none">• HealthCheck Screener Case Management Terms of Reimbursement (F-01114)
Risk Level	<ul style="list-style-type: none">• Enrollment: Limited• Revalidation: Limited
Disclosure Information	<ul style="list-style-type: none">• Final Rule Disclosure Information• Code of Federal Regulations Terminations and Criminal Convictions Information
Category of Enrollment	<ul style="list-style-type: none">• Billing and Rendering
Border Status	<ul style="list-style-type: none">• Eligible
Other Important Information	<ul style="list-style-type: none">• Medicaid-enrolled primary care physicians, certified pediatric nurses, or family nurse practitioners are automatically enrolled for HealthCheck. Other physician specialties, physician assistants, and nurse practitioners are encouraged to request enrollment as HealthCheck providers. Public health agencies and certain other providers, where physician supervision is available, may apply for enrollment as a HealthCheck agency.
Additional Documents	<ul style="list-style-type: none">• HealthCheck Screener Affirmation (F-11285)• HealthCheck Outreach Case Management Plan (F-11289)
Application Fee	<ul style="list-style-type: none">• Yes

Figure 9 - Medicaid HealthCheck Provider Criteria

Criteria

As indicated, enrollment criteria are defined in the administrative code:

WI Administrative Code: DHS 105.37 Early and periodic screening, diagnosis and treatment (EPSDT) providers.

EPSDT - HEALTH ASSESSMENT AND EVALUATION SERVICES.

Eligible providers. The following providers are eligible for certification as providers of EPSDT health assessment and evaluation services:

- Physicians;
- Outpatient hospital facilities;
- Health maintenance organizations;
- Visiting nurse associations;
- Clinics operated under a physician's supervision;
- Local public health agencies;**
- Home health agencies;
- Rural health clinics;
- Indian health agencies; and
- Neighborhood health centers.

Procedures and personnel requirements.

EPSDT providers shall provide periodic comprehensive child health assessments and evaluations of the general health, growth, development and nutritional status of infants, children and youth. **Immunizations shall be administered at the time of the screening if determined medically necessary and appropriate.** The results of a

⁴ All information regarding Medicaid provider enrollment has been taken from the ForwardHealth portal at <https://www.forwardhealth.wi.gov/WIPortal/Enrollment%20Criteria/tabid/325/Default.aspx>. All updates can be found at that location.

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health assessment and evaluation shall be explained to the recipient's parent or guardian and to the recipient if appropriate.

NPI

Only NPI Entity Type 2 is valid for this program.

Risk Level

As a result of the ACA, providers are categorized by risk level - high, moderate, or limited. This determination is made by CMS, based on an assessment of potential for fraud, waste, and abuse for each provider type.

HealthCheck Risk Level = Limited

- Verification of provider-specific requirements, including but not limited to the following:
 - License verification
 - NPI check
 - OIG exclusion check
 - Ownership/controlling interest information verification

Category of Enrollment

There are three categories of enrollment:

- Billing/rendering provider
- Rendering-only provider
- Billing-only provider (including group billing)

The EPSDT program requires the provider to be a **Billing/Rendering** provider. Enrollment as a billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Enrollment Fee

Provider organizations will be assessed a provider enrollment application fee when applying for Wisconsin Medicaid enrollment. This includes newly enrolling providers and providers who are re-enrolling after the provider's enrollment with Wisconsin Medicaid lapses for longer than one year, as long as all licensure and enrollment requirements are still met. The fee is established by the Centers for Medicare and Medicaid Services (CMS) and may be adjusted annually. The enrollment application fee is used to offset the cost of federally mandated screening activities associated with the ACA. The application fee for 2013 is set at \$532. Providers should note that CMS may adjust the fee on January 1 of each year.

Providers will **not be required to pay** ForwardHealth the enrollment application fee **if providers are currently enrolled in Medicare** or another state's Medicaid or Children's Health Insurance Program (CHIP). ForwardHealth will verify the provider's enrollment in Medicare or with another state. If the provider is currently enrolling in Medicare or another state's Medicaid or CHIP and has paid the fee, ForwardHealth will verify the provider has paid the application fee to Medicare or another state.

Enrollment

The enrollment process can be completed online.

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1) Go

to <https://www.forwardhealth.wi.gov/WIPortal/Certification%20Home%20Page/tabid/328/Default.aspx> to access the enrollment application (**Figure 10**) and click on the application under the *To Start a New Medicaid Enrollment* box. You don't not have to complete the application in one session. If you are returning for another session to complete it, you access through *To Continue a Previous Medicaid Enrollment* box on the same screen.

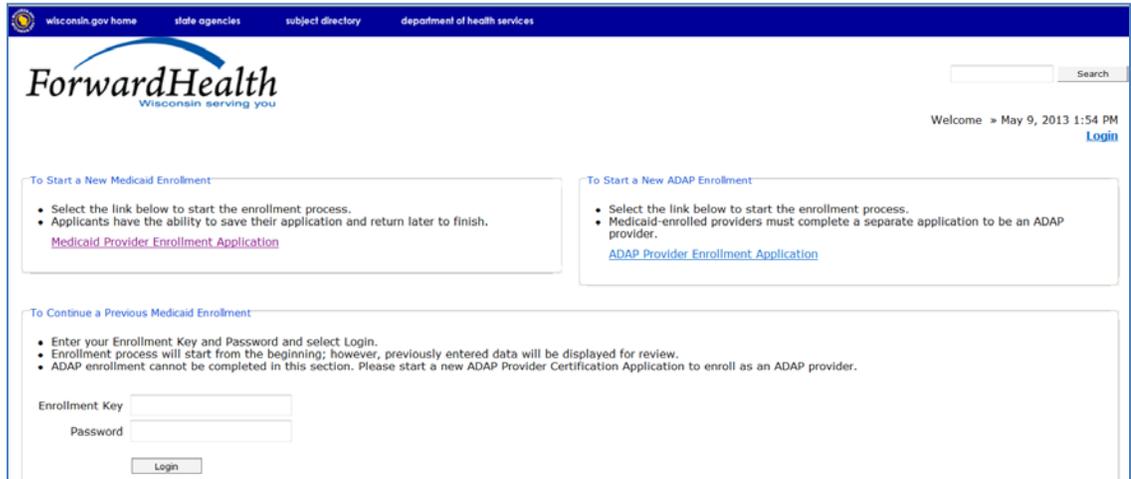


Figure 10 - Medicaid New Provider Enrollment Log-in Screen

2) When you initially open the application, you will be at the Instructions page (**Figure 11**). Pay specific attention to how to save and submit your application. Begin, and continue through the application using the **NEXT** button at the bottom of each page. Use **PREVIOUS** button to go back a page. **DO NOT** use your browser's back buttons – they are not enabled in the ForwardHealth system and may cause you to lose data.

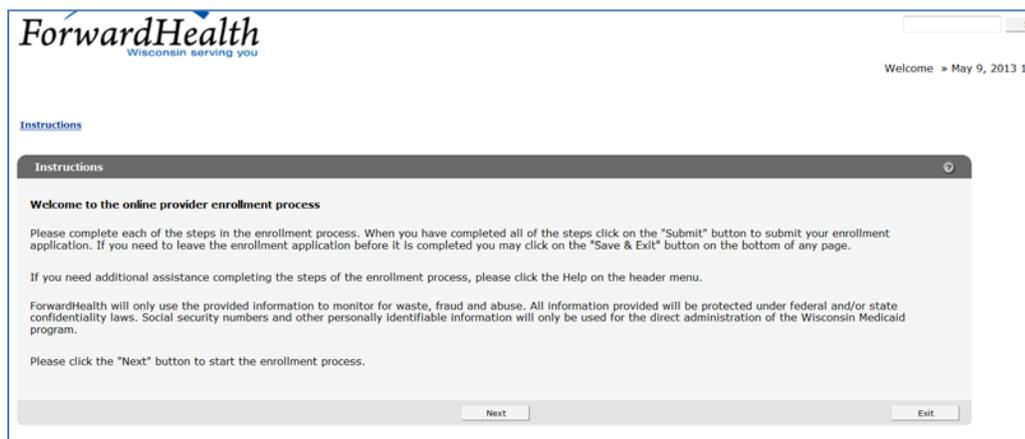


Figure 11 - Medicaid Provider Enrollment Instruction Page

3) Complete all the required fields.

4) Required documentation can be uploaded in the following formats:

- i) Joint Photographic Experts Group (JPEG) (.jpg or .jpeg).
- ii) Portable Document Format (PDF) (.pdf).
- iii) Rich Text Format (.rtf).
- iv) Text File (.txt).

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v) Comma Delimited (.csv).

5) The HealthCheck Screener provider codes (**Figure 12**) used in ForwardHealth are:

Specialty Code	Description
080	Federally Qualified Health Center
733	Case Management Only
734	Screener
735	Screener/Case Management

Figure 12 - Medicaid HealthCheck Screen Provider Codes

- 6) You can save a partially completed application and return to finish completing it within 10 *calendar* days. After 10 *calendar* days have passed, you will have to start a new application. You will have an Enrollment Key and password – be sure to write them down if you want to return to an incomplete application later; these are not able to be retrieved by anyone else.
- 7) You will receive an application tracking number (ATN) once a completed application has been submitted.
- 8) As part of the enrollment application, providers are required to sign a provider agreement with the Department of Health Services (DHS), which remains in effect as long as the provider is enrolled in Wisconsin Medicaid.
- 9) ForwardHealth will not accept paper checks or cash for enrollment application fee payments. Providers will have 10 business days to pay the fee after the application is submitted. ForwardHealth will not start processing their enrollment application until the application fee is paid.
- i) At the end of the provider enrollment application, providers can click on the Submit Enrollment Application Fee (**Figure 13**) or Hardship Request link to pay their enrollment application fee.

The screenshot shows the 'Payment Log in' interface on the ForwardHealth website. The page has a blue header with navigation links: 'wiscnsin.gov home', 'state agencies', 'subject directory', and 'department of health services'. The ForwardHealth logo is on the left, and a search bar is on the right. Below the logo, there is a 'Payment Log in' section with a form. The form has three input fields: 'ATN*', 'Tax ID*', and 'ZIP Code*'. Below the form is a 'Log In' button and an 'Exit' button. The page also shows a 'Welcome' message and the date 'May 9, 2013 2:42 PM'.

Figure 13 - Medicaid Application Fee Payment screen

- ii) Providers paying the application fee after submitting their application can pay the fee on the Provider Enrollment Information home page by clicking on the Submit Application Fee or Hardship Request link under the Provider Enrollment Application Fee topic.
- iii) If ForwardHealth does not receive the payment within 10 business days after the application is submitted, the application will be denied. If an application fee is not paid due to insufficient funds, the application will be denied.

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- 10) The status of an application may be tracked through the Certification Tracking Search (**Figure 14**) page at <https://www.forwardhealth.wi.gov/WIPortal/Enrollment%20Tracking/tabid/74/Default.aspx> using your ATN. Current information, such as whether the application is being processed or has been returned for more information, will be displayed. You can also contact Provider Services for information on the status.

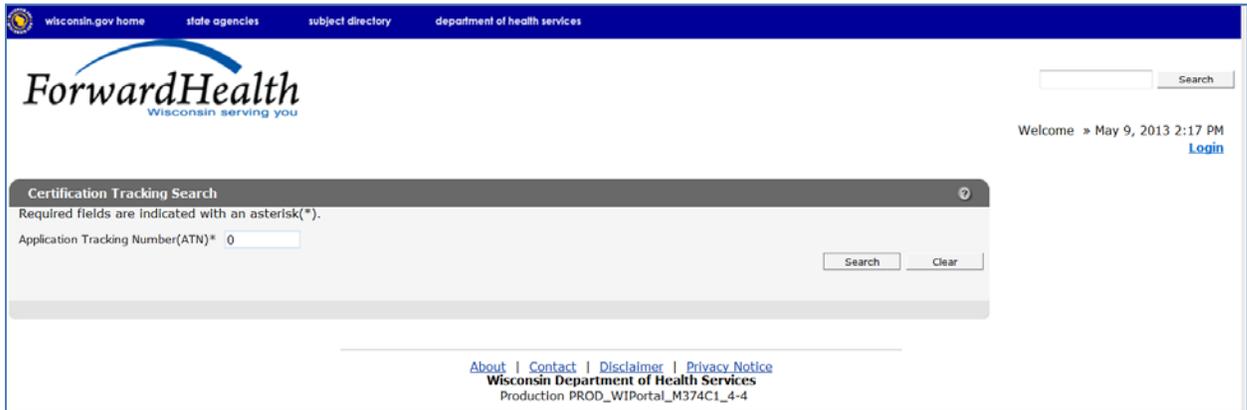


Figure 14 - Medicaid Certification Tracking Search screen

ForwardHealth
Provider Services Call Center
(800) 947-9627
M-F - 7:00 A.M. - 6:00 P.M. (CT)
(Closed on State of Wisconsin observed holidays)

- 11) Providers are required to wait for the Notice of Enrollment Decision as official notification that enrollment has been approved. This notice will contain information the provider needs to conduct business with Wisconsin Medicaid, BadgerCare Plus, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.
- 12) Wisconsin Medicaid will notify the provider of the status of the enrollment usually within 10 business days, but no longer than 60 days, after receipt of the complete enrollment application. The notification is by letter with a copy of the provider agreement.

