Frequently Asked Questions – Chapter 200: Provider Enrollment

Guam Medicaid and Medically Indigent Program (MIP)

Intended Audience: DPHSS staff, Guam Medicaid and Guam Medically Indigent Program providers and applicants, and other external stakeholders

GENERAL

1. **What is the purpose of Chapter 200, Provider Enrollment?**

Chapter 200 is the first of seven chapters in the new Provider Enrollment Manual. It explains the requirements for providers to enroll and participate in Guam Medicaid and Guam MIP. It applies to individual providers, institutional providers, and providers of medical equipment, goods, and services.

These FAQs are to answer initial questions and more detailed guidance and training is forthcoming.

2. **Who must be enrolled with Guam Medicaid/MIP?**

Any provider delivering services or supplies to Guam Medicaid/MIP beneficiaries must be enrolled and approved by Guam Department of Public Health and Social Services (DPHSS) before billing for covered services. Providers who order, refer, or prescribe covered services must also be enrolled, even if they do not submit claims directly.

Providers who furnish services as part of an organization or group must also enroll individually in the Guam Medicaid/MIP programs. Enrollment as a member of an organization or group does not replace the requirement for individual provider enrollment.

3. **How do I apply? Can I apply in person or by phone?**

The Department is currently revising processes related to the application and further guidance will be forthcoming.

4. **I have another question about provider enrollment that is not addressed here. How can I submit a question, and when can I expect a response?**

For provider enrollment questions related to the draft Provider Enrollment Manual, submit your questions to:

- Email: PublicComment@dphss.guam.gov

INITIAL ENROLLMENT

5. **When should I start my enrollment application?**

Applications are generally processed in the order that they are submitted, and response time can vary based on application volume and submission timing. DPHSS recommends submitting initial applications at least 90 days in advance of planned services so that enrollment eligibility is decided timely.

6. **What is the difference between enrolling as an individual and enrolling as an organization?**

Only providers enrolled as an organization may bill for services provided by other enrolled providers. Individual providers may bill for services they personally provide. Providers enrolled as a clinic, or with a clinic specialty, may bill as a billing provider with another provider listed as the rendering or attending provider.

7. **What documents are required to enroll as a provider in the Guam Medicaid/MIP programs?**

Required documentation may include:

- Valid license or certification
- Active National Provider Identifier (NPI) confirmation
- Tax ID or Social Security Number (SSN)
- Business registration or articles of incorporation
- Drug Enforcement Administration (DEA) certification
- Clinical Laboratory Improvement Amendments (CLIA) certification
- Disclosure of ownership and controlling interests
- W-9 form
- Electronic Funds Transfer (EFT) form and a deposit slip
- Proof of malpractice or liability insurance
- Signed Provider Agreement

See Table 2 of Chapter 200 for the complete required documentation list.

8. **What eligibility requirements must providers meet?**

Providers must meet all applicable requirements for licensure, certification, credentialing, NPI, tax identification, ownership disclosure, and federal and risk-based screening. Providers must also sign a provider agreement and comply with all applicable federal and Guam laws, regulations, policies, and program instructions.

9. **What screening activities might be required?**

Centers for Medicare and Medicaid Services (CMS) exclusion screening requirements depend on the provider's assigned risk level. Screening may include verification that the provider:

- Holds a valid license in the applicable state or territory
- Is not listed on the Office of Inspector General (OIG) exclusion database or the System for Award Management (SAM.gov)
- Passes site-visit inspection
- Passes fingerprint-based criminal background checks

10. **What are the provider risk levels?**

Centers for Medicare and Medicaid Services (CMS) requires Medicaid programs to assign each provider a categorical risk level of “limited,” “moderate,” or “high,” based on potential for fraud, waste, or abuse. If a provider falls into more than one category, the highest applicable level applies.

- **Limited Risk**: Providers and supplier types that present the lowest risk of fraud, waste, and abuse. These providers generally undergo basic verification and database screening. Examples include physicians, nurse practitioners, clinical psychologists, etc.
- **Moderate Risk**: Providers that present a greater potential risk than limited risk providers and therefore require additional screening measures. Examples include Independent Diagnostic Testing Facilities (IDTFs), revalidating home health agencies, Community Mental Health Centers (CMHCs), etc.
- **High Risk**: Providers and suppliers that present the highest potential risk of fraud, waste, and abuse and therefore require the most extensive screening. Examples include newly enrolling home health agencies, newly enrolling Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, etc.

11. **When are site visits required?**

Site visits are required for providers designated as moderate or high risk. They may occur before or after enrollment and are used to verify the accuracy of application information and confirm compliance with federal and territorial enrollment requirements. If a provider refuses access for a required site visit, Guam Medicaid/MIP must deny or terminate enrollment unless it determines, in writing, that doing so is not in the program’s best interests.

12. **What is the provider agreement?**

The provider agreement is a legally binding contract between the provider and DPHSS. It requires providers to:

- Comply with all program rules and applicable laws
- Maintain required records for at least seven (7) years

- Make records available to authorized agencies upon request
- Meet all ownership and control disclosure requirements
- Use NPIs on all Medicaid claims
- Ensure employees and contractors comply with agreement terms

13. **What identification numbers are assigned after enrollment?**

Approved providers receive:

- A vendor identification number – used for fiscal transactions and payment reporting
- Portal user credentials – used to submit claims and manage enrollment information

REVALIDATION OF ENROLLMENT

14. **How often must providers complete revalidation?**

Providers must be revalidated at least once every five (5) years. Revalidations may be needed outside the routine five (5) year cycle based on program integrity concerns or administrative conditions. Revalidation includes submitting updated enrollment information and completing risk-based screening, which may include licensure verification, exclusion screening, site visits, and fingerprint-based criminal background checks.

Enrolled providers are responsible for completing Medicaid revalidation requirements upon request by Guam Medicaid/MIP. Providers must submit all required forms, disclosures, licenses, certifications, and supporting documentation within the time frame specified in the revalidation notice. Failure to timely respond to a revalidation request or failure to provide requested information may result in termination of Medicaid enrollment and billing privileges in accordance with federal and territorial requirements.

15. **What happens if a provider does not complete revalidation?**

Failure to complete revalidation by the required due date may result in deactivation or termination of enrollment. Providers may not receive Medicaid/MIP payments until revalidation and all required screening activities are successfully completed. Payments made during a lapse in enrollment may be subject to recovery.

16. **When should I submit my revalidation information to avoid a lapse in enrollment?**

For revalidation, the agency will contact the provider to revalidate and provide the deadline to complete and submit the application for revalidation. DPHSS recommends submitting revalidation materials at least 90 days before the due date. Applications are processed in the order received, and response times may vary based on volume. Early submission helps prevent any gap in payment eligibility.

CHANGES TO ENROLLMENT

17. **How must providers report changes to enrollment information?**

Providers must report changes to enrollment information within 35 calendar days of the change occurring. Changes that must be reported include ownership or control interests, managing employees, practice locations, addresses, name, telephone or fax numbers, Medicare status, group membership, specialty, federal tax identification number (TIN), or billing agent.

18. **What is required for a change of ownership?**

Providers must notify Guam Medicaid/MIP of a proposed change of ownership at least 60 days before the change occurs. The new owner must submit a new provider agreement. If the agreement is not received before the ownership change takes effect, there may be a gap in enrollment. Payments received during that gap may be subject to recovery.

19. **When may enrollment be denied or terminated?**

Enrollment may be denied or terminated for a variety of reasons, including:

- Criminal convictions related to Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) within the past 10 years
- Termination under Medicare or another state or territory Medicaid program
- Failure to submit timely or accurate information
- Failure to submit fingerprints when required
- Failure to allow required site visits
- Exclusion or sanction on a federal or state exclusion list
- Incomplete application or missing documentation
- False or misleading information
- Noncompliance with licensure or program requirements

COSTS AND FEES

20. **Are application fees required? How much is the enrollment fee?**

Application fees are required for institutional providers and suppliers when enrolling, reenrolling, revalidating, or adding a new practice location. Examples of institutional providers and suppliers include hospitals, home health agencies, skilled nursing facilities, medical equipment suppliers, and pharmacies. **Individual physicians and nonphysician practitioners are not required to pay this fee.**

The application fee amount is set by CMS and applies to Medicaid enrollment. For the current fee amount, visit CMS Medicare Learning Network, Provider Enrollment Resources.

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html

21. **Can a provider request hardship exception to be excused from the application fee?**

Yes. Guam Medicaid/MIP may grant a hardship exception on a case-by-case basis. A provider should submit a written request explaining the hardship, along with supporting documentation, together with the enrollment application.

22. **Can a provider be paid for services rendered while not enrolled in Guam Medicaid or MIP?**

Generally, providers may not be reimbursed for services rendered before the effective date of their enrollment. Retroactive enrollment start dates are limited. Providers should not render services to Medicaid or MIP beneficiaries until enrollment has been confirmed.

DECISIONS

23. **Is there a formal appeals process for enrollment decisions?**

If an application is denied, the provider may resubmit the application with any necessary corrections.

24. **What are moratoria?**

Moratoria are temporary restrictions that stop enrollment of certain provider types. CMS or Guam Medicaid/MIP may impose a moratorium when a provider type presents a significant potential risk for fraud, waste, or abuse. Access to care must be considered before imposing a moratorium. Moratoria are initially imposed for six (6) months and may be extended in six-month (6) increments.

OFF-ISLAND SERVICES

25. **What should providers know about off-island U.S. and foreign providers?**

The Department is creating guidance applicable to off-island providers, which will be released at a later date.