Healthy Connections

FREQUENTLY ASKED QUESTIONS

Provider Enrollment and Screening Requirements

Updated August 2015

SOUTH CAROLINA
Healthy Connections
MEDICAID

Frequently Asked Questions

Enrollment and Screening 3
Who initiated the new screening and enrollment guidelines? 3
When will the new screening and enrollment guidelines be implemented? 3
What are some of the new provider screening and enrollment guidelines? 3
How can I obtain more information regarding the new provider screening and other enrollment requirements? 4
Risk Categories 4
How are providers categorized by risk categories? 4
Will the entities in each screening category stay the same? 5
Can a provider be moved from one risk category to another? 5
Application Fee 6
Explain the Medicaid application fee and how much is it? 6
If I am currently enrolled in Medicare or with Medicaid in another state, will I have to go through the entire enrollment and screening process and pay another application fee to enroll in South Carolina Medicaid? 7
Ordering and Referring Providers 7
Can a billing provider be an ordering or referring provider as well? 7
How can a provider check to see if the ordering/referring physician is enrolled with Medicaid? 7
Temporary Moratorium 7
What is a Temporary Moratorium? 7
Status of Enrollment 8
How long does the enrollment process take? 8
How can we get an enrollment status update? 8
Why did my enrollment application get rejected after I made the corrections I was told to? 8
Link a Provider to a Group 8
How do I enroll a new provider who has joined our group? 8
Where do I list the individuals affiliated with our group on the enrollment application? 8
Why is the group enrollment effective date before the date our individual provider joined the group? 9
Why didn't the mailing address also update when I affiliated the individual provider to our group? 9
Update Profile 9

Why can't we update our enrollment profile over the phone? 9
How do I update the individual provider's name? 9
Claims 10
Will my claims from two weeks ago process if I just enrolled today?..... 10
Other Questions 10

Enrollment and Screening

Who initiated the new screening and enrollment guidelines?

The Centers for Medicare and Medicaid Services (CMS), under standards established by the Affordable Care Act (ACA), with a focus on strengthening requirements for Medicaid provider screening and other enrollment requirements.

When will the new screening and enrollment guidelines be implemented?

Although indicated in a May 9, 2012 Medicaid Bulletin and letter to State Agencies this would be implemented by August 1, 2012, due to delays a new implementation date will be targeted and communicated to providers in future bulletins. Prior to implementation, provider outreach activities will focus on communication of the new policies and other related information. New screening and enrollment information will be distributed through Medicaid bulletins, SCDHHS website messages and alerts, training and orientation activities for certain programs and updates to Program Manuals.

What are some of the new provider screening and enrollment guidelines?

- Enhanced provider screening and enrollment based on risk categories (limited, moderate and high) for fraud, waste and abuse for each provider type as assigned by CMS and the SCDHHS.
- Background checks and unannounced pre and post enrollment site visits.
- Fingerprint-based criminal history records checks. At the present time, the criminal background checks and fingerprinting are not required.
- Updated Disclosure of Ownership and Controlling Interest Statements
- Enrollment of ordering/referring providers
- Suspension of provider Medicaid payments in cases of credible allegations of fraud
- Denial of enrollment and/or termination of a provider from the Medicaid program "for cause". This is defined as the revocation of Medicaid billing privileges for

specific reasons such as denial/termination from the Medicare program, denial/termination from other state Medicaid and Children's Health Insurance Programs, or other reasons based on credible allegations of fraud, integrity or quality.

- Institution of application enrollment fees for business organizations and entities that are enrolling with South Carolina Medicaid with an Employee Identification Number (EIN).
- Implementation of a temporary moratorium on new provider enrollments, when instructed by CMS, to protect against high risk of fraud and abuse.
- Revalidation of enrolled providers at least every five years, with the exception of DME providers, who need to revalidate every three years.

How can I obtain more information regarding the new provider screening and other enrollment requirements?

A link to the Federal Register, Vol 76, No. 22, dated February 2, 2011, can be found on the SCDHHS website at SCDHHS.gov.

Risk Categories

How are providers categorized by risk categories?

Three levels of screening (limited, moderate and high) are recognized for those provider types that are also recognized provider or supplier types under Medicare. For those provider types that are not recognized under Medicare, SCDHHS has assessed the risk of fraud, waste and abuse using similar criteria to those used in Medicare. See the list below for SCDHHS risk categories:

Limited Risk:

(State-regulated and State-licensed would generally be categorized as limited risk)

- Physician or non-physician practitioners and medical groups or clinics (excluding Physical Therapists and Physical Therapists Groups)
- Nursing Homes, Hospitals, Public and Private Community Mental Health Centers,
- Audiologists, Certified Nurse Midwife/Licensed Midwife, Certified Registered
- Nurse Anesthetists, Anesthetist Assistants, CMS Parts A & B, Managed Care
- Organizations, Licensed Marriage and Family Therapists, Licensed Professional
- Counselors, Licensed Independent Social Workers –Clinical Practice,
- Psychologists, Speech Therapists, Nurse Practitioners, Physician's Assistants,
- Occupational Therapists, Physicians, Speech and Hearing Clinics, End Stage Renal

- Disease Clinics, DHEC Clinics, Federally Qualified Health Clinics, Federally Funded Health Clinics and Rural Health Centers, Ambulatory Surgical Centers, Diabetes
- Education Clinics, School Districts, Developmental Rehabilitation Clinics, Infusion
- Centers, Pediatric Aids Clinics, Maternal and Child Health Clinics, Dentists,
- Opticians, Optometrists, Podiatrist, Chiropractors, Pharmacy, Pharmacy Part D,
- Individual Transportation Providers, Contractual Transportation Providers , Transportation Broker, X-Ray (not portable)

Moderate Risk:

(Highly dependent on Medicare, Medicaid and CHIP to pay salaries and other operating expenses and which are not subject to additional governmental or professional oversight and would be considered moderate risk)

- Rehabilitative Behavioral Health Services, Physical Therapists , Comprehensive Outpatient Rehabilitation Facilities (CORFs), Hospice Providers, Community Long
- Term Care (individuals and groups), Independent Laboratories, X-Ray (portable), Ambulance and Helicopter Providers
- Currently enrolled (revalidating Home Health Agencies)
- Currently enrolled (revalidating DMEPOS)

High Risk:

(Identified by the State as being especially vulnerable to improper payments and would be considered as high risk)

- Proposed (newly enrolling) Home Health Agencies (HHAs), Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Will the entities in each screening category stay the same?

CMS will continuously evaluate whether they need to change the assignment of categories of providers and suppliers to various risk categories. If they assign certain groups of providers and/or suppliers to a different category, this change will be proposed in the Federal Register.

Can a provider be moved from one risk category to another?

Yes, providers can be reassigned from the “limited” or “moderate” categories due to:

- Imposition of a payment suspension within the previous 10 years
- A provider or supplier has been terminated or is otherwise precluded from billing Medicaid

- Exclusion by the OIG
- A provider or supplier has been excluded from any federal health care program
- A provider or supplier has had billing privileges revoked by a Medicaid contractor within the previous 10 years
- A provider or supplier has been subjected to a final adverse action (as defined in 42 CFR 424.502) within the past 10 years
- Instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicaid provider or supplier at any time within 6 months from the date the moratorium was lifted.

Application Fee

Explain the Medicaid application fee and how much is it?

For 2015, SCDHHS must collect a $553 application fee prior to executing a provider agreement whether upon an initial enrollment, reactivation, revalidation or an enrollment to add a new practice location. [Note: $542 for 2014.] The provider enrollment application fee is applicable to providers that the Centers for Medicare & Medicaid Services (CMS) has identified as institutional providers. South Carolina Healthy Connections Medicaid recognizes and enrolls the following institutional providers: Ambulatory Surgery Centers, Community Mental Health Centers; Comprehensive Outpatient Rehabilitation Facilities; Durable Medical Equipment, End Stage Renal Disease Facilities; Federally Qualified Health Centers; Home Health Agencies; Hospices; Hospitals, Acute Inpatient Facilities, Inpatient Psychiatric Facilities, Inpatient Rehabilitation Facilities, Independent Clinical Laboratories; Skilled Nursing Facilities and Rural Health Clinics.

The fee is to be used to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes. This fee can vary from year to year based on adjustments made pursuant to the Consumer Price Index for Urban Areas (CIP-U). A provider will be exempt from the fee if they have submitted and received approval for a Hardship Waiver request or they can demonstrate they are enrolled or have paid the application fee to Medicare and/or another state's Medicaid or CHIP for the same enrollment location jurisdiction. A different enrollment jurisdiction means "a new enrollment with an address different from a currently enrolled location." Individual physicians (sole proprietors enrolling with an EIN and Social Security Number (SSN) are considered individuals), non-physician practitioners and non-physician practitioner organizations are exempted from paying the enrollment application fee.

If I am currently enrolled in Medicare or with Medicaid in another state, will I have to go through the entire enrollment and screening process and pay another application fee to enroll in South Carolina Medicaid?

If you are currently enrolled as a Medicare provider or enrolled in another state's Medicaid program or CHIP, SCDHHS will rely on the enrollment and screening results obtained by Medicare or your state's Medicaid Program to satisfy SCDHHS provider enrollment and screening requirements as long as the information is less than 12 months old. (Otherwise, SCDHHS will conduct a complete screening.) No application fee is required for providers that have already paid the fee to Medicare or another state's Medicaid/CHIP program for the same enrollment location jurisdiction. A different enrollment jurisdiction means "a new enrollment with an address different from a currently enrolled location." You will be required to complete the SCDHHS enrollment application and provide supporting documentation, if applicable.

Ordering and Referring Providers

Can a billing provider be an ordering or referring provider as well?

Yes, as long as the provider is not designated as an ordering/referring provider exclusively. Future edits will prevent claims payment if an ordering/referring-only provider submits their NPI as a billing provider.

How can a provider check to see if the ordering/referring physician is enrolled with Medicaid?

On the SCDHHS website SCDHHS.gov, there is a searchable listing of *Enrolled Providers* under the *For Providers* tab. If the provider is not listed, then the provider is not currently enrolled with Medicaid. You may also contact the Provider Service Center at 1 (888) 289-0709, option 4 to verify the provider's enrollment.

Temporary Moratorium

What is a Temporary Moratorium?

A temporary moratorium is the imposition of a hold or freeze on the enrollment of new or initial Medicaid providers and suppliers of a particular provider type or the establishment of new practice locations of a particular provider type in a specific geographic area for a period of six months. CMS may extend a temporary moratorium in six month increments. The announcement of a moratorium will be reported in the Federal Register.

Status of Enrollment

How long does the enrollment process take?

Enrollment applications will be processed within thirty (30) business days from the date of receipt. The thirty (30) business day timeframe may be exceeded for enrollment applications that require: additional information, a site visit, a contractual agreement, or are submitted with sanction information.

How can we get an enrollment status update?

Contact the Provider Service Center (PSC) (888) 289-0709, option 4 for Provider Enrollment. Please have your Reference ID number available.

Why did my enrollment application get rejected after I made the corrections I was told to?

A provider is notified about rejections via the Enrollment Rejection Letter. The rejection letter indicates the reason(s) for the rejection. For further assistance, contact the Provider Service Center at 1 (888) 289-0709, option 4.

Link a Provider to a Group

How do I enroll a new provider who has joined our group?

Individuals can be added anytime to a group without having to pay an application fee. If an individual wants to be added to a group that is not currently enrolled, the group will have to pay an application fee and enroll. Once the group is enrolled, the individual must then request to be added to the group. If the individual provider is already enrolled in South Carolina Medicaid, submit in writing an update request to have the provider affiliated with the group. The request must be on the business letterhead to include the Group's Medicaid Legacy ID number and the provider's NPI number with the provider's or an authorized signature via Fax: (803) 870-9022 or Mail: Medicaid Provider Enrollment, PO Box 8809 Columbia, SC 29202-8809. Updates will be processed within ten (10) days of receipt. If the individual provider is currently in the process of enrolling, the provider can indicate on the online application group affiliation.

Where do I list the individuals affiliated with our group on the enrollment application?

During the online enrollment process, organizations cannot affiliate individuals to their group. It is the responsibility of the individual provider to affiliate with a group. The

request must be on the business letterhead to include the Group's Medicaid Legacy ID number and the provider's NPI number with the provider's or an authorized signature via Fax: (803) 870-9022 or Mail: Medicaid Provider Enrollment, PO Box 8809 Columbia, SC 29202-8809. Updates will be processed within ten (10) days of receipt.

Why is the group enrollment effective date before the date our individual provider joined the group?

When an Individual provider is affiliated with a group, the original group enrollment date remains the same regardless of when the individual provider was affiliated. The individual provider does not receive a new enrollment date when affiliated with the group.

Why didn't the mailing address also update when I affiliated the individual provider to our group?

Affiliating an individual provider with a group does not automatically update any other information on the individual provider's record. The request must be in writing if the individual provider's record information needs updating. Submit the request on the business letterhead with the provider's or an authorized signature via Fax: (803) 8709022 or Mail: Medicaid Provider Enrollment, PO Box 8809, Columbia, SC 29202-8809. Updates will be processed within ten (10) days of receipt.

Update Profile

Why can't we update our enrollment profile over the phone?

SCDHHS requires updates to a provider's file to be submitted in writing on business letterhead with the provider's or an authorized signature. Submit any updated changes via Fax: (803) 870-9022 or Mail: Medicaid Provider Enrollment, PO Box 8809, Columbia, SC 29202-8809. Updates will be processed within ten (10) days of receipt.

How do I update the individual provider's name?

SCDHHS requires the individual provider to send in a completed/signed W9 form with the individual's name, SSN, address and signature. Providers are also required to complete the Disclosure of Ownership and Control Interest Statement Form.

Claims

Will my claims from two weeks ago process if I just enrolled today?

Upon approval of enrollment (the provider has met all necessary requirements); the enrollment date of the provider's effective date will retroactively begin 90 days prior to the date of receipt of the application. However, depending on the provider's type/ specialty, if the provider is required to sign a contractual agreement in addition to the provider enrollment agreement, the enrollment date is the effective date of the contract. Note: Medicaid will not pay for claims prior to an enrollment effective date or before the provider's licensure/certification date.

Why are our claims denying for dates of service prior to the individual provider leaving the practice?

Prior to requesting the removal of an Individual provider from your group practice ensure that the pending claims are adjudicated. However, if the provider has already been removed from the group prior to the claim(s) being adjudicated and needs to be added back to the group, submit the request on the business letterhead with the provider's or an authorized signature via Fax: (803) 870-9022 or Mail: Medicaid Provider Enrollment, PO Box 8809, Columbia, SC 29202-8809. Updates will be processed within ten (10) days of receipt.

Other Questions

Will a provider be notified if they are terminated "for cause" and do they have appeal rights?

Yes, a provider will be notified via certified mail when terminated for cause. The provider does have appeal rights.