South Carolina Health & Human Services

Provider Screening Requirements

FAQ Guide

~FREQUENTLY ASKED QUESTIONS~
FEDERAL REGULATION CHANGES FOR PROVIDER SCREENING AND OTHER ENROLLMENT

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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 2012, SCDHHS must collect a $523 application fee from business organizations and entities that are enrolling in South Carolina Medicaid with an Employee Identification Number (EIN). 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). The application fee will be imposed on business organizations and entities that are enrolling in South Carolina Medicaid that are: (1) initially enrolling, (2) adding a practice location and (3)

revalidating enrollment information *at least every five years (with the exception of DME providers, who must revalidate every three years).*

Providers that are EXEMPT from the application fee are: Individual physicians or non-physician practitioners who have already enrolled in the Medicare program or another State's Medicaid program or CHIP.

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?

No, 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. You will be required to complete the SCDHHS enrollment application and provide supporting documentation, if applicable. No application fee is required for providers that the State is not required to rescreen.

ORDERING AND REFERRING PROVIDERS

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

Yes. All individual billing providers may be ordering and/or referring providers based upon the service(s) rendered.

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 listing of Enrolled Providers under the Useful Tools tab. You must know the provider's county residence and provider type in order to access the information. 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.

Other Questions

How are individuals added to a 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's not currently enrolled, the group will have to pay an application fee and enroll. Once the group is enrolled, the individual will be added to the group.

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.

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