CMS Starts Screening Providers and Suppliers and Adds Site Visits and Fingerprint-based Criminal Background Checks to the Process

The Centers for Medicare & Medicaid Services (CMS) has the continuing goal of reducing fraud, waste, and abuse through all available avenues. The *Affordable Care Act* requires CMS to determine the level of screening to be conducted during provider and supplier enrollment based on the **level of risk posed to the Medicare system.** With the enactment of the *Affordable Care Act*, CMS has the increased ability to focus efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid, and CHIP, and that only legitimate claims are paid.

Effective Friday, March 25, 2011, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories ”“ limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier, and determine the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Providers/suppliers in the “limited” screening category will include:

- Physicians
- Non-physician practitioners other than physical therapists
- 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)
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the *Indian Health Care Improvement Act*) or an urban Indian organization (as defined in section 4(29) of the *Indian Health Care Improvement Act*) that receives funding from the Indian Health Service pursuant to Title V of the *Indian Health Care Improvement Act*
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Pharmacies that are newly enrolling or revalidating via the CMS-855B application

- Radiation Therapy Centers
- Religious non-medical health care institutions
- Rural Health Clinics
- Skilled Nursing Facilities

Providers in the "moderate" screening category will include:

- Ambulance service suppliers
- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent Diagnostic Testing Facilities (IDTFs)
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRS)
- Revalidating Home Health Agencies (HHAs)
- Revalidating DMEPOS suppliers

Providers in the "high" screening category will include:

- Newly-enrolling DMEPOS suppliers
- Newly-enrolling Home Health Agencies (HHAs)
- Providers and suppliers reassigned from the "limited" or

“moderate” categories due to triggering events.

Triggering events include the following instances:

- 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 had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location;
- a provider or supplier has been excluded from any federal health care program;
- a provider or supplier has been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years; or
- 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 Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

The enrollment screening procedures will vary depending upon the categories described above. Screening procedures for the “limited” screening category will largely be the same as those currently in use; screening procedures for the “moderate” screening category will include all current screening measures, as well as a **site visit**; screening procedures for the “high” screening category will include all current screening measures, as well as a site visit and, at a future date a **fingerprint-based criminal background check**.

CMS will continuously evaluate whether a change of the assignment of categories of providers and suppliers to the various risk categories is necessary. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the *Federal Register*. However, CMS will not publish a notice or a proposed rule in the *Federal Register* that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.