TENNCARE POLICY MANUAL

Policy No: PRO 16-001 (Rev. 1)	
Subject: Provider Screening Requirements	
Approved by: Dennis Elliott	**Date:** 10-12-16

PURPOSE:

The purpose of this policy is to provide an overview of TennCare's screening requirements for providers wishing to deliver services to TennCare enrollees.

BACKGROUND:

Section 6401(a) of the Affordable Care Act required the U.S. Secretary of Health and Human Services, in consultation with the Office of the Inspector General, to establish procedures for screening providers participating in Medicare, Medicaid, and CHIP. The Secretary was directed to establish screening levels for different types of providers based on an assessment of each provider type's relative risk for fraud, waste, or abuse.

Section 6401(b) of the Affordable Care Act required state Medicaid programs to comply with the procedures established by the Secretary for screening providers. The Centers for Medicare & Medicaid Services (CMS) implemented these screening requirements in 2011 with federal regulations at 42 CFR Part 455 subpart E.

POLICY:

All providers seeking to participate in TennCare are subject to TennCare's provider screening requirements. The level of screening required is based on the provider type's level of risk for fraud, waste, or abuse. Provider types deemed to pose a higher risk of fraud, waste, and abuse are subject to more screening requirements than provider types that generally pose a lower risk of fraud, waste, and abuse.

In general, TennCare assigns provider types to the same categorical risk levels used by CMS in the Medicare program. This assignment of provider types to different risk levels is based on CMS' assessment of each provider type's relative risk for fraud, waste, or abuse. For provider types that are

not eligible to participate in Medicare, TennCare has determined the most appropriate risk level based on an assessment of the risk posed by the provider type.

TennCare groups providers into categorical risk levels as indicated in Table 1.

Table 1
Categorical Risk Levels and Associated Provider Types

Categorical Risk Levels	Associated Provider Types
Limited risk	Physician or nonphysician practitioners and medical groups or clinics; ambulatory surgical centers; Competitive Acquisition Program/Part B vendors; end-stage renal disease facilities; federally qualified health centers (FQHCs); histocompatibility laboratories; hospitals; home and community based service (HCBS) providers; Indian Health Service facilities; intermediate care facilities for individuals with intellectual disabilities (ICFs/IID); mammography screening centers; mass immunization roster billers; non-emergency medical transportation (NEMT) providers; organ procurement organizations; pharmacies newly enrolling or revalidating via the CMS-855B application; radiation therapy centers; religious non-medical health care institutions; rural health clinics; skilled nursing facilities
Moderate risk	Ambulance service suppliers; community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent clinical laboratories; independent diagnostic testing facilities; physical therapists enrolling as individuals or as group practices; portable x-ray suppliers; revalidating home health agencies; revalidating DMEPOS[1] suppliers
High risk	Newly enrolling home health agencies; newly enrolling DMEPOS suppliers; any provider of any provider type who has previously been excluded from TennCare or from a federal health care program

TennCare's screening procedures for providers in the various risk categories are described below.

Screening Requirements for Providers in the "Limited Risk" Category

Providers in the limited risk category are subject to the following screening requirements:

1. Verification that the provider meets any applicable federal regulations or state requirements for the provider type prior to registering the provider;
2. Verification that the provider meets applicable licensure requirements; and
3. Database checks on an ongoing basis to ensure that the provider continues to meet the applicable criteria for their provider type.[2]

[1] "DMEPOS" refers to durable medical equipment, prosthetics, orthotics, and supplies.

[2] Database checks may include (but are not limited to) verification of Social Security Number (SSN) and National Provider Identifier (NPI); the National Practitioner Data Bank (NPDB); licensure; the existence of any HHS OIG exclusion; taxpayer identification; tax delinquency; or the death of an individual practitioner or owner.

Screening Requirements for Providers in the "Moderate Risk" and "High Risk" Categories

Providers designated as moderate or high risk are subject to all of the same screening requirements that providers in the limited risk category are subject to. In addition, moderate and high risk providers are subject to additional screening requirements as described below.

Moderate risk providers are subject to unscheduled or unannounced site visits as described at 42 CFR §455.432. TennCare providers are required to permit TennCare, TennCare's managed care organizations (MCOs), and/or CMS to conduct these site visits at any and all provider locations.

High risk providers are also subject to unscheduled or unannounced site visits. In addition, federal regulation requires high risk providers to undergo a criminal background check, including the submission of a set of fingerprints.[3] The background checks required for high risk providers include any persons with a five percent or more direct or indirect ownership interest in the provider.

For provider types recognized by Medicare, TennCare requires that moderate and high risk providers seeking to participate in TennCare be enrolled in Medicare, pursuant to authority granted to states under 42 CFR §431.51. TennCare will verify the provider's enrollment in Medicare using the Provider Enrollment, Chain, and Ownership System (PECOS). If TennCare can verify the provider's enrollment in Medicare through PECOS, then TennCare will rely on the provider screening conducted by Medicare to register the provider. If the provider's enrollment in Medicare cannot be verified through PECOS, then TennCare will not register the provider.

For provider types that are *not* recognized by Medicare, TennCare will be responsible for the required provider screening. When conducting criminal background checks for high risk providers, TennCare conducts a fingerprint-based criminal background check (FCBC) as required by federal regulation.

The screening requirements for providers in the three categorical risk levels are summarized in Table 2.

Table 2
Summary of Provider Screening Requirements

Applicable Provider Screening Requirements	Limited Risk	Moderate Risk	High Risk
Verification of any provider-specific requirements	X	X	X
Conduct license verifications	X	X	X
Database checks	X	X	X
Unscheduled or unannounced site visits		X	X
Fingerprint-based criminal background check			X

[3] See 42 CFR §455.434.

Previously Excluded Providers

The high risk category includes providers who have been previously excluded from TennCare or any federal health care program. In addition to the screening requirements described above, which are applicable to all providers, providers who have been excluded and who are seeking reentry into TennCare are subject to review by TennCare's Provider Review Committee (PRC). If all other screening requirements have been met, the PRC will review a previously excluded provider's registration request and make a determination whether to register the provider. These determinations are at the discretion of the PRC.

NOTE: Almost all TennCare services are delivered by managed care contractors (MCCs) with which TennCare has contracted. Providers must be registered with TennCare in order to receive payment for services delivered to TennCare enrollees. However, TennCare registration does not obligate the managed care contractors to contract with a particular provider. Providers wishing to deliver services to TennCare enrollees must register with TennCare, and must also contract with one or more of the MCCs to become a part of their provider network.

OFFICES OF PRIMARY RESPONSIBILITY:

Office of Provider Services

REFERENCES:

Affordable Care Act, Section 6401
http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

42 CFR Part 455 subpart E
http://www.ecfr.gov/cgi-bin/ECFR?page=browse

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