HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

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COMPLIANCE ALERT 11-06

CMS Issues Final Rule for New Screening Procedures for Providers and Suppliers

CMS has issued a final rule that establish screening procedures for providers and suppliers. The rule also discusses compliance plan requirements for providers and suppliers. The rule implements provisions of the Affordable Care Act.

Compliance: This rule does not implement any explicit new requirements for compliance programs. However, it does reiterate that nursing facilities and SNFs "shall have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care, consistent with regulations developed by the [HHS] Secretary, working jointly with the HHS OIG." The published rule asks for specific comments on the use of the OIG's seven elements for effective compliance programs that are the basis for HHSC's compliance program and states that further mandatory compliance program requirements will be published at a later date.

Screening Criteria: According to the rule published in the Federal Register (Vol. 76, No 22), the new rule "makes a number of changes to the Medicare and Medicaid programs and CHIP that enhance the provider and supplier enrollment process to improve the integrity of the programs to reduce fraud, waste, and abuse in the programs."

Good news for HHSC: The screening process for most of our providers will remain the same as we currently do.

Changes in Screening Criteria--Categories of Providers. A major change is that different types of providers require different screening criteria. The new rule designates provider and supplier categories that are subject to certain screening procedures "based on CMS' assessment of fraud, waste and abuse risk of the provider or supplier category, taking into consideration a variety of factors." These factors include CMS background information on claims data used to identify fraudulent billing practices. '

To provide complete information, the following six questions and answers from the CMS website are included below:

What are these risk levels or screening categories?

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. " The Table below summarizes the screening criteria required:

PROPOSED SCREENING LEVELS AND PROCEDURES FOR MEDICARE PHYSICIANS, NON-PHYSICIAN PRACTITIONERS, PROVIDERS, AND SUPPLIERS (from the Federal Register, 76,22)

Type of screening required	Limited	Moderate	High
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X
Conduct license verifications, (may include licensure checks across States)	X	X	X
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Unscheduled or Unannounced Site Visits		X	X
Criminal Background Check			X
Fingerprinting			X

Which categories of providers are in which level of screening?

- 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

- o Mammography screening centers
- o Mass immunization roster billers
- o Organ procurement organizations
- o Pharmacies that are newly enrolling or revalidating via the CMS-855B application
- o Radiation Therapy Centers
- o Religious non-medical health care institutions
- o Rural Health Clinics
- o Skilled Nursing Facilities

- Providers in the "moderate" screening category will include:
  - o Ambulance service suppliers
  - o Community Mental Health Centers (CMHCs)
  - o Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - o Hospice organizations
  - o Independent clinical laboratories
  - o Independent Diagnostic Testing Facilities (IDTFs)
  - o Physical therapists enrolling as individuals or as group practices
  - o Portable x-ray suppliers (PXRS)
  - o Revalidating Home Health Agencies (HHAs)
  - o Revalidating DMEPOS suppliers
- Providers in the "high" screening category will include:
  - o Newly-enrolling DMEPOS suppliers
  - o Newly-enrolling HHAs
  - o 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.

What impact will these categories have on providers?

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.

When will the provider screening categories be implemented?

These new screening requirements by level of risk will be implemented on March 25, 2011. The only portion of this new screening procedure that will not be implemented in March will be the fingerprint- based criminal background checks. We will provide information on these background checks at a later date.

Why is CMS making these screening categories?

It is the continuing goal of the Centers for Medicare & Medicaid Services (CMS) to reduce 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, we have the increased ability to focus our 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.

Will the entities in each screening category stay the same?

CMS will continuously evaluate whether we need to change the assignment of categories of providers and suppliers to the various risk categories. 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.

Source: http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf