# Chapter 15. Provider Screening and Enrollment

**§1501. General Provisions**

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 and 42 CFR Part 455, Subpart E, the Medicaid Program adopts the following provider enrollment and screening requirements. The Centers for Medicare and Medicaid Services (CMS) has established guidelines for provider categorization based on an assessment of potential for fraud, waste, and abuse for each provider type. The Medicaid Program shall determine the risk level for providers and will adopt these federal requirements in addition to any existing requirements. Additional enrollment requirements may be adopted in the future.

B. In accordance with PPACA and federal regulations, the Medicaid program shall screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation, utilizing the following guidelines.

1. Provider types shall be categorized by the following risk levels:

a. high categorical risk—categories of service that pose a significant risk of fraud, waste, and abuse to the Medicaid program;

b. moderate categorical risk—categories of service that pose a moderate risk of fraud, waste, and abuse to the Medicaid program;

c. limited categorical risk—categories of service that pose a minor risk of fraud, waste, and abuse to the Medicaid program.

C. Screening activities for the varying risk levels shall include the following mandates.

1. High risk level screening activities shall include:

a. fingerprinting and criminal background checks for all disclosed individuals;

b. unannounced site visits before and after enrollment; and

c. verification of provider-specific requirements including, but not limited to:

i. license verification;

ii. national provider identifier (NPI) check;

iii. Office of Inspector General (OIG) exclusion check;

iv. disclosure of ownership/controlling interest information; and

v. the Social Security Administration's death master file check.

2. Moderate risk level screening activities shall include:

a. unannounced site visits before and after enrollment; and

b. verification of provider-specific requirements including, but not limited to:

i. license verification;

ii. NPI check;

iii. OIG exclusion check;

iv. disclosure of ownership/controlling interest information; and

v. the Social Security Administration's death master file check.

3. Limited risk level screening activities shall include, but are not limited to:

a. verification of provider-specific requirements including:

i. license verification;

ii. NPI check;

iii. OIG exclusion check;

iv. disclosure of ownership/controlling interest information verification; and

v. the Social Security Administration's death master file check.

D. The Medicaid Program may rely on, but is not limited to, the results of provider screenings performed by:

1. Medicare contractors;

2. Medicaid agencies; or

3. Children's Health Insurance Programs (CHIP) of other states.

E. Updated Medicaid enrollment forms shall require additional information for all disclosed individuals.

F. Providers shall be required to revalidate their enrollments with the Medicaid Program at a minimum of

five year intervals. A more frequent revalidation requirement, a minimum of three year intervals, shall apply to durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialty enrollments. All providers shall be required to revalidate their enrollment under PPACA and Medicaid criteria.

1. Existing providers shall be revalidated in phases, with completion scheduled for March 23, 2015.

G. Provider Screening Application Fee

1. In compliance with the requirements of the Affordable Care Act and 42 CFR 455.460, the department shall collect an application fee for provider screening prior to executing provider agreements from prospective or re-enrolling providers other than:

a. individual physicians or non-physician practitioners; and

b. providers who:

i. are enrolled in title XVIII of the Social Security Act;

ii. are enrolled in another state's title XIX or XXI plan; or

iii. have paid the applicable application fee to a Medicare contractor or another state.

2. The department shall return the portion of all fees collected which exceed the cost of the screening to CMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1051 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:920 (May 2018).