



## 610 AHCCCS PROVIDER QUALIFICATIONS

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REVIEW DATE: 10/01/13

INITIAL

EFFECTIVE DATE: 10/01/1994

All providers of AHCCCS-covered services, both Fee-For-Service [FFS] and managed care shall:

1. Register with the AHCCCS which requires signing the Provider Participation Agreement or Group Biller Participation Agreement that includes all federal and state requirements as applicable, and
2. Comply with all federal, state, and local laws, rules, regulations, executive orders and agency policies governing performance of duties under this agreement.
3. Effective August 2, 2012, sign and return attestations found on the Provider Registration section of the AHCCCS website that are applicable to their individual practices or facilities.
4. Meet AHCCCS requirements for professional licensure, certification or registration including current Medicare certification.
5. Complete all applicable registration forms.
6. Institutional and other designated providers are required to submit an enrollment fee, effective January 1, 2012 (See the Exhibit 610-1).
7. Specific provider types will require an AHCCCS Office of the Inspector General (AHCCCS-OIG) site visit prior to enrollment, and are subject to unannounced post enrollment site visits (See Exhibit 610-1).

AHCCCS registration is mandatory for consideration for payment by:

1. AHCCCS for services rendered by FFS providers, and
2. AHCCCS Contractors for services rendered by managed care providers as well as submission of encounter data to the AHCCCS Administration by the Contractors.



**A. AHCCCS PROVIDER REGISTRATION MATERIALS**

AHCCCS-OIG Provider Registration materials are available on the AHCCCS web site. Click on the “Plans/Providers” tab. On the “New Providers” click on the “Provider Reenrollment” tab. The forms can be completed on the AHCCCS website; however, must be submitted by fax or mail.

**B. AHCCCS PROVIDER TYPES**

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician) established by AHCCCS. The AHCCCS-OIG Provider Registration Section will assist providers in identifying the most appropriate provider type, based on the provider's license/certification and other documentation.

**C. SCREENING OF PROVIDERS BASED ON CATEGORICAL RISK**

As part of the implementation of the Section 6401 of the Affordable Care Act, Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), CMS requires that AHCCCS comply with the following provisions:

1. To screen providers according to the provisions of Part 455 subpart E under 42 CFR 455.450.
2. To screen all applications, including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation, based on a categorical risk level of “limited,” “moderate,” or “high.” 42 CFR 455.410(a).
3. To establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid Program.
4. When AHCCCS determines that a provider’s categorical risk level is “high,” or when the agency is otherwise required to do so under State law, the agency must require providers to consent to criminal background checks, including fingerprinting.

Exhibit 610-2 contains all the applicable requirements for each risk category as defined by CMS and AHCCCS. Not all providers are required to pay enrollment fees, these are only applicable to institutional providers.

AHCCCS is not required to conduct a Fingerprint Based Criminal Background Check (FCBC) on a “high” risk provider if that provider is considered a “high” risk provider by Medicare and the provider has been enrolled by Medicare. (Under 42 CFR 424.518(c), Medicare considers newly enrolling home health agencies and suppliers of Durable



Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to be “high” categorical risk).

Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the “high” risk provider and any person with a five percent or more direct or indirect ownership interest in the provider, as those terms are defined in 42 CFR 455.101.

#### **D. RISK ASSESSMENT AND CRITERIA FOR RISK ADJUSTMENT**

In accordance with 42 CFR 455.450 AHCCCS-OIG will adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

1. AHCCCS imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse; the provider has an existing Medicaid overpayment; or the provider has been excluded by the HHS-OIG or another State's Medicaid program within the previous 10 years.
2. AHCCCS or CMS in the previous six months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

AHCCCS-OIG Provider Registration will notify each high-risk provider regarding the fingerprint based background checks. The individual(s) subject to the FCBC requirement will be listed as part of the notification process and will have 30 days to comply, from the date of notification. AHCCCS-OIG Provider Registration will notify the provider with a 15-day notification letter to remind the provider of the fingerprint background requirement.

Once the individual(s) have complied with the requirement, AHCCCS-OIG Provider Registration will send the fingerprints to the Department of Public Safety (DPS) to complete the background check. Upon receipt of the background results, AHCCCS-OIG Provider Registration ‘designee’ will review results and elevate any individual(s) with a criminal history to the AHCCCS-OIG High Risk Provider Review Committee (HRPRC) to review. The provider will be issued an AHCCCS provider identification number if the results are positive. If AHCCCS-OIG Provider Registration denies the enrollment based on the FCBC results, the individual(s) or provider will be notified. The notice will include the appeal rights in accordance with A.R.S. §36-2903.01.B.4 and A.R.S. §41-1092.01 et seq.

In accordance with the CMS SMD 15-002, a provider that has failed to comply with the FCBC requirement or fails the background check must be terminated or the agency has a basis to deny their enrollment, unless AHCCCS determines that termination is not in the best interests of the Medicaid Program and documents that determination in writing.



**CHAPTER 600**  
**PROVIDER QUALIFICATIONS AND PROVIDER REQUIREMENTS**

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**POLICY 610**  
**AHCCCS PROVIDER QUALIFICATIONS**

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Exhibit 610-1 identifies the complete list of AHCCCS Medicaid provider types. The list identifies the registration requirements per provider type along with the regulatory organization(s) for providers of AHCCCS covered services. Refer to AMPM Chapter 300 for a description of all AHCCCS-covered services. Refer to AMPM Chapter 1200 for long-term care services, and the Behavioral Health Services Guide for behavioral health services.

Refer to the AHCCCS website for additional information regarding provider registration requests.