5101:3-1-17.8 **Provider screening and application fee.**

(A) To become an eligible provider as described in rule 5101:3-1-17 of the Administrative Code, a provider must meet the screening requirements described in this rule and pay an applicable application fee if required in the appendix to this rule. Provider screening and application fees are required at the time of enrollment and re-enrollment as defined in rule 5101:3-17.4 of the Administrative Code.

(1) Exemptions from this rule.

(a) If a provider is required to participate in the medicare program as a condition of enrollment in medicaid or elects to participate in the medicare program and has met the provider screening requirements and paid an applicable application fee to the centers for medicare and medicaid services (CMS) or its designee, the provider is exempt from this rule.

(b) If a provider has met the provider screening requirements and paid an applicable application fee to another state medicaid agency or its designee, the provider is exempt from this rule.

(c) A provider must provide documentation to support it meets the criteria for an exemption described in paragraphs (A)(1)(a) and (A)(1)(b) of this rule.

(2) The appendix to this rule sets forth:

(a) The screening risk level assigned to each provider type in accordance with paragraph (B) of this rule; and

(b) The provider types that must pay an application fee in accordance with paragraph (C) of this rule.

(B) Screening requirements differ by risk level. If more than one risk level could apply to a provider, the highest level of screening is required.

(1) Limited.

(a) Providers are subject to verification that they meet any applicable medicaid requirements as stated in division 5101:3 of the Administrative Code for their provider type; and

(b) Providers are subject to license verifications, including state licensure verification in states other than Ohio; and

(c) Providers are subject to database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type.

(i) Database checks must confirm the identity and exclusion status of providers and any person with a five per cent or greater ownership or control interest; or any person who is an agent or an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the provider entity.

(ii) Databases to be checked include, but are not limited to, the social security administration's death master file, the national plan and provider enumeration systems (NPPES), the list of excluded individuals/entities (LEIE), and the excluded parties list system (EPLS).

(2) Moderate.

(a) Providers are subject to the requirements in paragraph (B)(1) of this rule; and

(b) Providers are subject to on-site visits.

(i) Pre- and post-enrollment site visits by the Ohio department of job and family serivces (ODJFS) or its designee will verify that information provided to ODJFS or its designee is accurate and to determine compliance with medicaid enrollment requirements.

(ii) Once enrolled, providers must allow CMS or its agents or contractors, or ODJFS or its agents or contractors to conduct unannounced on-site inspections of any and all provider locations.

(3) High.

(a) Providers are subject to the requirements in paragraphs (B)(1) and (B)(2)(b) of this rule; and

(b) Each person with a five per cent or greater ownership or control interest with the provider is subject to a criminal background check and is required to submit his or her fingerprints within thirty days of submission of the application in a form and manner determined by ODJFS, or its designee.

(C) Application fee.

(1) Provider types identified as subject to an application fee in the appendix to this rule must submit the fee in a form and manner determined by ODJFS at the time of application for enrollment or re-enrollment as a medicaid provider. If

proof of fee payment is not submitted with the provider's application, the application will be denied.

(2) The application fee is equal to the amount established by CMS and includes an annual adjustment for inflation in accordance with paragraph (a)(2)(C)(i) of 42 U.S.C. 1395cc(j).

(3) The application fee will not be refunded if:

(a) Enrollment is denied as a result of failure to meet the provider screening requirements described in this rule; or

(b) If enrollment is denied based on the results of the provider screening.

(D) If enrollment is denied as a result of failure to meet the provider screening requirements or failure to pay any associated application fee, the provider may request a hearing pursuant to Chapter 119. of the Revised Code.

Effective:

R.C. 119.032 review dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02, 5111.063
Rule Amplifies:	5111.02, 5111.063