

Provider Screening Requirements

Revised: [August 13, 2024](#)

Minnesota Health Care Programs (MHCP) continues to review enrollment records to identify providers due for required revalidation. MHCP will attempt to rely on Medicare enrollment information whenever possible.

MHCP is required to follow the Centers for Medicare & Medicaid Services (CMS) final federal provider screening regulations that were effective March 25, 2011.

These regulations require you to do the following:

- You must revalidate your existing provider enrollment record when notified to do so by MHCP Provider Eligibility and Compliance.
- If you are going through enrollment, reenrollment or revalidation, you are subject to new screening actions based on risk of fraud, waste or abuse of Medicare and Medicaid funding.
- If you are considered a moderate or high-risk provider, MHCP will conduct unannounced site visits of your locations.
- MHCP will collect application fees before enrollment, reenrollment or revalidation:
 - For new applications
 - At the time of and before completion of reenrollment or revalidation

If you are actively enrolled with and already paid the application fee to Medicare or to another state within the last five years, you are not subject to the fee upon enrollment or revalidation with MHCP.

Continue to visit this page frequently to review the most up-to-date information about the MHCP screening requirements and processes.

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Risk Levels

CMS has established the following three risk levels for providers: limited, moderate and high. It has assigned one of these risk levels to each provider type that enrolls with Medicare.

MHCP uses the same Medicare risk levels assigned by CMS for provider types that are eligible to enroll with both Medicare and MHCP. For provider types that are not eligible to enroll with Medicare, MHCP has assigned risk levels.

Refer to the [Risk Levels and Enrollment Verification Requirements](#) section of this manual and the [CMS Medicare Program Integrity Manual, Screening Categories \(PDF\)](#) for information.

Change of Risk Level

MHCP is required to assign a high-risk level to an individual provider or provider organization when any of the following conditions exists:

- A payment suspension is imposed because of a credible allegation of fraud, waste or abuse.
- The provider has an existing Medicaid overpayment.

- The provider has been excluded by the Office of Inspector General (OIG) or another state’s Medicaid program within the last 10 years.

A provider type is also assigned a high-risk level for the first six months after a state Medicaid agency or CMS lifts a temporary moratorium for that provider type.

Screening Actions

All providers are subject to some type of screening action. Some screening actions are required for all provider types. Others are specific to provider types with a high or moderate risk level. The table shows the screening actions required for provider types with each risk level.

Screening Actions Required for Each Risk Level

Screening Action	Risk Level Subject to the Screening Action		
	Limited	Moderate	High
Provider-specific requirements verification	X	X	X
Licensure verification (including licensure checks across states, if applicable)	X	X	X
Database checks (to verify the National Provider Identifier [NPI]; U.S. Department of Health and Human Services OIG exclusion; Excluded Parties List System [EPLS] exclusion; death of individual practitioner or of a person who has an ownership or control interest, or who is an agent or managing employee of the provider; and termination by Medicare or another state’s program)	X	X	X
Unscheduled or unannounced site visits		X	X
Criminal background check (based on fingerprints)			X
Fingerprinting			X

Revalidation

If you are currently enrolled with MHCP, you must revalidate your enrollment records at least once every five years (except for PCA agencies which must revalidate their enrollment records once every three years).

Revalidation occurs when MHCP notifies you to complete and update all enrollment documents to continue participation with MHCP. Revalidation requires you resubmit all enrollment documents like a new enrollment. Refer to the [Enrollment with MHCP](#) page to find the enrollment requirements for your provider type.

MHCP sends you a notice with instructions for revalidation based on your provider risk level and provider type file. You can expect to receive an initial revalidation notice as soon as 3 ½ years after the most recent revalidation or enrollment date. Note the following requirements for the revalidation process:

- You have 30 days from the date on the notice to upload your required documents in the [Minnesota Provider Screening and Enrollment \(MPSE\) portal](#) or fax in all required documents.
- If MHCP does not receive all required information, we will send you a request for more information (RFMI) notice asking for the remaining required information to complete revalidation. This information is due 30 days from the date on the RFMI notice.

- If we do not receive all required information 30 days after the RFMI notice date, we will send you a 60-day notice of termination including provider appeal rights and options for reenrolling after termination.
- Review the [Revalidation for MHCP Providers](#) on-demand video for information on the MHCP [revalidation](#) process.

If you are enrolled as more than one provider type, you will receive a separate notice for each type. If you are consolidated and have more than one file for a provider type, you will receive one notice with instructions to send the required information for each file.

To ensure the most effective and efficient processing of revalidation paperwork for providers that have been scheduled for revalidation, and to prevent processing backlogs, wait to send revalidation documents until you receive your initial revalidation notice.

Enroll Each Location

If you have more than one business location that provides a service, you must follow the instructions for new enrollments and enroll each business location.

Your Enrollment May End

If you do not meet enrollment requirements for revalidation, MHCP will notify you that we have terminated your enrollment. This notice will include your appeal rights. We can terminate your enrollment at revalidation for any of the following screening reasons:

- Failure to submit all required documents within the required timeframe
- Nonpayment of a required enrollment fee
- Failure to meet enrollment qualifications, such as:
 - Lack of required licensure or certification
 - Failure to document other requirements of enrollment
 - Refusal to allow access for a site inspection

If you do not submit all required documentation within the required timelines and do not comply with all screening requirements, MHCP may revoke your billing privileges and terminate your enrollment ([Minnesota Statutes, 256B.04, subdivision 22](#) and [256B.064](#)).

Personal Care Assistance (PCA) Agencies

If your enrollment with MHCP ends for your PCA agency, you must immediately notify the county or counties where your MHCP members live. Inform the county that you can no longer be reimbursed for services as an MHCP provider, and that the county should take actions to ensure the safety of the members ([Minnesota Statutes, 626.557](#)). Any terminated PCA provider agency, including all named individuals on the current enrollment disclosure form, and known or discovered affiliates of the PCA provider agency, is not eligible to enroll as a PCA agency for two years following the termination ([Minnesota Statutes, 256B.0659, subdivision 23](#)).

Using Medicare Screening for Revalidation

MHCP received additional guidance from CMS on how we may rely on the Medicare screening for revalidation of providers that are active and dually enrolled with both Medicare and MHCP. MHCP must verify certain data elements for both individual and organization providers based on their assigned risk category through the Medicare Provider Enrollment, Chain and Ownership System (PECOS) to consider a provider revalidated. MHCP can rely on the Medicare data if a dually enrolled provider matches the necessary data elements. Providers that have already received a request for revalidation must still comply with that request.

Refer to the chart on page 54 in the [Medicaid Provider Enrollment Compendium \(MPEC\)](#) for details about Medicare provider screening elements.

Once MHCP verifies that a provider meets the minimum required data elements, we will send a notice that states their revalidation is complete. If MHCP is unable to verify the minimum required data elements, we will send a revalidation request letter to the provider to submit his or her revalidation documentation.

Revalidation Schedule

For all other providers that enrolled or reenrolled with MHCP, we will request that you complete your revalidation at least once within every five years (or three years for PCA agencies). Starting January 2024, revalidation notices will be sent out every month on the 15th (or the next business day if the 15th is on a weekend or holiday). You will receive a revalidation request letter to notify you that a revalidation is due. MHCP will place revalidation request letters into the **PRVLTR** folder of your MN-ITS mailbox using the schedule in the following Initial Revalidation table. Refer to the [MN-ITS Mailbox User Guide](#) for instructions on using the mailbox.

If you do not have a registered MN-ITS account, MHCP will send the revalidation request letter via U.S. Postal Service. If you received your revalidation request letter through the U.S. Postal Service, you need to register your MN-ITS account to be sure you get future notifications. The Welcome Letter you received when you first enrolled has instructions. If you do not have a copy of your Welcome Letter, call the [MHCP Provider Resource Center](#) to ask for a copy.

You can also see if you are due for revalidation using the [Minnesota Provider Screening and Enrollment \(MPSE\)](#) portal. Log into MN-ITS and click on the MPSE portal link. This will open the **Manage Portfolio** page. Go to the **Revalidations** section and click on the **Manage Enrollment Records Due for Revalidation** link. This will take you to the **Enrollment Records with a Revalidation In-Process** page which will display a list of enrollment records due for revalidation. Review the [Revalidation MPSE User Manual](#) page for additional instructions on completing your revalidation in the MPSE portal.

2024 Initial Revalidation Date	Provider Type
April 15, 2024	<ul style="list-style-type: none"> • Birthing Center - provider type B1 • Home Care Nursing Agency (HCN) Group - provider type 64 • Optical Company - provider type 75 • Certified Mental Health Rehabilitation Professional - provider type 26
May 15, 2024	<ul style="list-style-type: none"> • Certified Nurse Specialist (CNS) - provider type 68 • Home and Community-Based Services providers - provider type 18 • Independent Laboratory - provider type 80
June 15, 2024	<ul style="list-style-type: none"> • Home and Community-Based Services providers - provider type 18 • Physician Assistant – provider type 69 • Physicians – provider type 20-I • Physician Clinics – provider type 20-O
July 15, 2024	<ul style="list-style-type: none"> • Billing Entity for Physician Group - provider type 49 • Home and Community-Based Services providers - provider type 18 • Individualized Education Program (IEP) Services – provider type 09

	<ul style="list-style-type: none"> • Federally Qualified Health Center (FQHC) - provider type 52 • Optical Company – provider type 75 • Rehabilitation Billing Entity - provider type 48
August 15, 2024	<ul style="list-style-type: none"> • Home and Community-Based Services providers - provider type 18 • Intermediate Care Facilities (ICF) • Physicians – provider type 20-I • Physician Assistants – provider type 69
September 15, 2024	<ul style="list-style-type: none"> • Personal Care Provider Organizations

Providers may receive a revalidation request letter outside of the revalidation schedule listed in the previous table if DHS determines your record is due for revalidation. Check your MN-ITS **PRVLTR** folder regularly for important notices, including notices that you are due for revalidation.

See [Past Revalidation Schedule](#) for provider types who we requested to revalidate in the past.

Site Visits

If your provider type has a moderate or high-risk level, MHCP will conduct preenrollment and post-enrollment site visits when you enroll, reenroll or revalidate enrollment. You must permit MHCP to conduct unannounced on-site inspections of any of your locations to comply with screening requirements.

MHCP will conduct an unannounced site visit within 60 days of the date we receive notice from the Department of Human Services' (DHS) Provider Eligibility and Compliance that you are enrolling, reenrolling or revalidating enrollment. If you do not cooperate during a preenrollment visit, we will not approve your enrollment application.

If you deny access to one of your locations during a site visit, we will either not approve your enrollment application or terminate your enrollment.

Application Fees

MHCP, like Medicare and all other states' Medicaid programs, must collect a **nonrefundable** application fee from "institutional providers of medical or other items or services or suppliers" to fund provider screening costs. If you are an institutional provider and are newly enrolling, reenrolling, or revalidating enrollment, you must pay the application fee. In 2023 the fee was \$688 per practice location. Effective Jan. 1, 2024, the fee is \$709 per practice location. If you are required to pay a fee, you must pay the fee that applies to the calendar year that we receive your application. We must receive your application fee before we can process your enrollment application.

CMS determines the application fee and it is subject to change every calendar year. CMS publishes the application fee in the Federal Register 60 days before each new calendar year.

Fees are **not** required of non-institutional providers, physicians and non-physician practitioners. This is regardless of whether they are in a small-group practice, unless the physician is also enrolling as a Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) supplier.

The following provider types are considered non-physician practitioners:

- Anesthesia assistants
- Audiologists
- Certified nurse-midwives

- Certified registered nurse anesthetists
- Clinical nurse specialists
- Clinical psychologists
- Dentists
- Dental hygienists
- Doulas
- Nurse practitioners
- Occupation and physical therapists in private practice
- Physician assistants
- Psychologists practicing independently
- Registered dieticians
- Speech language pathologists in private practice

Providers that Are Considered Institutional Providers

The federal screening law uses the term “institutional provider” differently from the way MHCP has traditionally used that term. According to the federal law, an institutional provider is not limited to hospitals, nursing facilities, and similar providers. For provider screening purposes, MHCP will consider an institutional provider to be any organizational provider that has a tax identification number (TIN) or federal employer identification number (FEIN). Institutional providers in the Institutional Provider lists are required to have FEINs. Individual providers who do not have a TIN or FEIN are not considered institutional providers.

Lists of Institutional Providers

A provider whose provider type appears on the following MHCP or Medicare list is considered an institutional provider that must pay the application fee if the provider is required to have a TIN or FEIN. A provider whose provider type does not appear on either of the following lists does not need to pay the fee.

List of MHCP Institutional Providers

The following MHCP institutional provider types are subject to the application fee. If your provider type is listed, and if you have not already paid the screening fee, then you are subject to the application fee for each new enrollment, reenrollment, and revalidation for each of your locations or provider type files enrolled with another state in the past five years.

- Adult Rehabilitative Mental Health Services (ARMHS)
- Birth centers
- Children’s Therapeutic Services and Supports (CTSS)
- Day Training and Habilitation (DT&H)
- Early Intensive Developmental and Behavioral Intervention (EIDBI) agencies
- Financial Management Services (FMS)
- Home and Community-Based Services (HCBS) and Alternative Care (AC) program providers (excludes those without a federal tax identifier)
- Institutions for mental disease (IMD)
- Intermediate care facilities for people with developmental disabilities (ICF/DD)
- Intensive Residential Treatment Services (IRTS)
- Nursing facilities
- PCA provider agencies (PCPOs)
- Providers of chemical health services
- Providers of children’s residential treatment
- Providers of day treatment
- Providers of home care nursing

- Providers of Individualized Education Programs (IEP) services
- Providers of targeted case management
- Nonemergency medical transportation providers
- Public health nursing organizations
- Recuperative care providers

List of Medicare Institutional Providers

Medicare defines the following provider types as institutional providers. If your provider type is listed, and if you have not already paid the screening fee for each of your locations to another state or Medicare in the past five years, you are subject to the application fee for each location for each new enrollment, reenrollment, and revalidation.

- Ambulances and Emergency Medical Transportation
- Ambulatory surgical centers (ASCs)
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS)
- End-stage renal disease facilities
- Federally qualified health centers (FQHCs)
- Histocompatibility laboratories and independent clinical laboratories
- Home health agencies (HHAs)
- Hospice providers
- Hospitals (including critical access hospitals)
- Independent diagnostic testing facilities (IDTFs)
- Indian Health Services (IHS)
- Mass immunizers (roster billers)
- Pharmacies
- Providers of outpatient physical therapy, occupational therapy or speech pathology services
- Portable x-ray suppliers (includes mammography centers)
- Rural health clinics (RHCs)
- Skilled nursing facilities (SNFs)

If a physician is also enrolled as a DMEPOS supplier to furnish items to his or her patients, the physician must pay the application fee for DMEPOS.

Enrolling providers, including those in a presidentially declared disaster area, may request a hardship exception to the application fee. CMS considers requests for hardship exceptions on a case-by-case basis. See the section titled "[Hardship Exemption](#)" for more information.

Multiple Provider Business location

If you enroll as more than one kind of institutional provider, you must pay a fee for each enrollment record. A fee is also required for institutional providers with more than one practice location.

Paying the Fee

MHCP has developed a web-based system for providers to submit their fee payments. The system allows you to pay for multiple locations in one transaction and accepts the following forms of payment:

- Credit card
- Debit card
- Electronic check

To access the payment system, go to [MHCP Provider Screening Fee Collections System](#). Determine which payment type to use based on your business transactions, card authorizations and usage limits. For questions about usage and limits, contact your financial institution.

If you are actively enrolled with and have already paid the fee to Medicare or another state within the last five years, you are not subject to the fee upon enrollment or revalidation with MHCP.

Review the screening requirements in this section of the MHCP Provider Manual to determine whether you are required to pay a fee.

Hardship Exemption

You may request an exemption from the application fee by completing the [Hardship Exemption Request Form \(DHS-3901\) \(PDF\)](#) and submitting it along with documentation supporting the request with the MHCP enrollment application. If you have multiple locations requesting a hardship exemption, you must complete and submit a separate form for each.

On the Hardship Exemption Request Form, describe the hardship and why the hardship justifies an exemption. Supporting documentation must clearly identify your provider's name and location requesting the exemption, and the documentation must show evidence of hardship supporting your request.

Supporting documents may include, but are not limited to, financial balance sheets, tax return documents, income expense reports, and any other document showing proof of financial hardship for your business location. MHCP will forward your request to the Centers for Medicare & Medicaid Services (CMS) for a determination. CMS may request additional information before making a final determination.

MHCP will not process your application until CMS has granted or denied your request and MHCP receives the final determination from CMS. If CMS grants the hardship exemption, MHCP will process your application. If CMS denies the hardship exemption, you must pay the application fee within 30 days of the date of the denial. If MHCP does not receive the fee within 30 days, we will deny the application.

Denial and Terminations

Any provider whose enrollment application is denied or whose enrollment is terminated by MHCP, Medicare or another state Medicaid agency must undergo screening and pay all applicable application fees again to enroll or reenroll with MHCP.

Exception: PCA agencies are unable to reapply for two years from the termination date if terminated due to noncompliance.

At the time of new enrollment, reenrollment, or revalidation, MHCP will deny or terminate the enrollment of a provider if any owner or authorized person (such as anyone with five percent or more direct or indirect ownership or control interest in the provider, any agent, or any managing employee):

- Does not submit to a fingerprint-based background study within 30 days of the request (applies only to owners)
- Is determined under state or federal law to have committed an offense that has resulted in, or would result in, an exclusion from, suspension of, or termination of, participation in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)
- Is terminated for cause by Medicare or any other state's Medicaid program or CHIP
- Does not submit timely and accurate disclosure information
- Fails to cooperate with all screening methods
- Fails to provide access to provider locations for site visits

- Falsifies information on an application

If MHCP denies a provider's application for cause, or terminates a provider's enrollment for cause, and the provider later submits an application for a new enrollment or reenrollment, the provider must again undergo screening and pay all applicable fees.

Legal References

[Final federal provider screening regulations, published Feb. 2, 2011](#)

[Code of Federal Regulations, title 42, section 455.450](#) (Screening levels for Medicaid providers)

[Minnesota Statutes, section 256B.04, subdivisions 21 and 22](#) (Provider enrollment; Application fee)