Checking Federal Databases to Verify Provider Identity Snapshot

Under the authority of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) increased the number of databases State Medicaid agencies (SMAs) must check when a provider applies to participate in Medicaid or the Children's Health Insurance Program (CHIP).[1, 2, 3] Providers, State program integrity officials, and managed care plans should be familiar with these databases and know how to use them. Federal health care programs will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.[4]

When a provider seeks to enroll, the SMA must check the following databases:

- The List of Excluded Individuals and Entities—Verify whether a provider has been excluded from participating in Federal health care programs;
- The National Provider Identifier Registry—Verify the provider's identity and National Provider Identifier (NPI). An NPI is a unique 10 position numeric identifier assigned to each health care provider;
- The National Plan and Provider Enumeration System (NPPES)—Verify the provider's NPI number and that the provider is a professional eligible to provide care under the Medicaid program;
- System for Award Management (SAM) Advance Search—Exclusions Database—Determine whether the provider has ever been debarred from participating in any Federal health care program;
- Social Security Administration records—Verify an individual provider's Social Security number; and
- Social Security Administration's Death Master File—Verify the individual provider listed in an application is a living person.

Guidance from CMS suggests SMAs also consider checking the Terminated Provider Database,[5] the Medicare Exclusion Database, and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).[6]

These database checking requirements have been in effect for fee-for-service providers since 2011. States will phase in these requirements for managed care providers by July 1, 2018.[7] Providers and State program integrity officials should keep in mind that SMAs are free to establish screening and disclosure requirements "in addition to or more stringent than" those required by the regulations.[8]

For More Information

More information on databases will be available in the forthcoming "Medicaid Provider Enrollment" Toolkit that will be posted to the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

To see the electronic version of this E-Bulletin and E-Bulletins on other topics posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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References

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2 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2011, February 2). Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers; Final Rule. 76 Fed. Reg. 5862, 5865-67. Retrieved May 27, 2016, from https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

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8 Other State Screening Methods. 42 C.F.R. § 455.452. Retrieved May 18, 2016, from http://www.ecfr.gov/cgi-bin/text-idx?SID=c829aaeac8da20ade3fc3cf2489d55b8&mc=true&node=se42.4.455_1452&rgn=div8

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