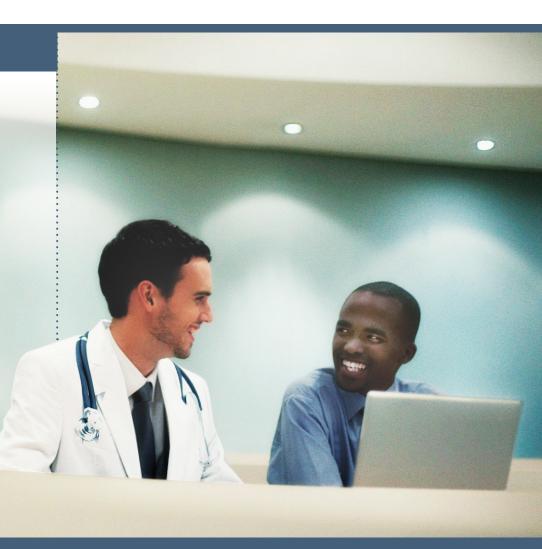# Provider Enrollment
Frequently Asked Questions (FAQ)

The purpose of this FAQ is to answer the questions that Texas Medicaid providers might have about changes to the Texas Medicaid program, provider enrollment, and program participation.

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TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Section 1:	Provider Revalidation

To remain in compliance with Title 42 Code of Federal Regulations (CFR) §455.414, all providers are required to revalidate enrollment information every three to five years, during which time required screening will be completed. In some situations, in compliance with Texas Administrative Code (TAC) §371.1015, providers may have to revalidate enrollment on a more frequent basis. You can submit your revalidation application up to 90 days before the revalidation due date. Texas Medicaid encourages all providers to confirm their current enrollment information in the Provider Information Management System (PIMS) prior to submitting your revalidation application.

See Also:

For more information about provider revalidation, see the Provider Enrollment page on the TMHP website.

1.1 What does revalidation entail?

Revalidation includes the submission of an online application, all additional documentation, and an application fee (see Section 4) to continue participation in Texas Medicaid. Receipt of a completed revalidation application will initiate the provider screening process (see Section 3).

The revalidation application is available in Provider Enrollment on the Portal (PEP). PEP will not allow a revalidation application to be submitted prior to 90 days before your revalidation due date for a specific TPI. This 90-day window allows you time to submit your application and correct any deficiencies or errors that may result from the application before your revalidation due date. Submitting your revalidation application as early as possible within those 90 days minimizes the chance that you will be disenrolled. Disenrollment will impact your claims and prior authorizations.

Revalidation renews Texas Medicaid enrollment for actively enrolled providers without interrupting their enrollment status. Re-enrollment is applicable to providers who have been disenrolled, excluded, teminated, or otherwise removed as a provider from Texas Medicaid (and are not currently able to receive payments) and who will need to submit a re-enrollment application to re-instate their enrollment.

1.2 Do providers have to initiate the Revalidation process or will it be initiated by TMHP?

Providers must initiate the Revalidation process up to 90 days before the due date.

1.3 I only provide Medicaid services through managed care organizations. Do I need to be enrolled?

Yes, you need to be enrolled. This requirement applies to those providing services through Medicaid managed care organizations (MCO), dental maintenance organization (DMO) or through traditional fee-for-service Medicaid.

Just as providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by an MCO or dental plan, providers must be revalidated to maintain their contract and credentialing with their plans. In order to maintain contracting and credentialing with your Medicaid MCOs and DMOs, please be sure you have completed the revalidation process prior to your due date.

If you don't complete the revalidation process by the due date, you will be disenrolled from all Texas state health-care programs and your claims and prior authorization requests will be denied.

In addition, if you do not submit a revalidation application before your enrollment period end-date/revalidation due date, you will be disenrolled from all Texas state health-care programs, including MCOs and DMOs and your claims and prior authorization requests will be denied.

1.4   Can I view my Revalidation status online?

Yes. Provider Enrollment and Provider Administrator accounts can view the revalidation status via Provider Information Management System (PIMS). Refer to the TMHP Portal Security Provider Training Manual for more information on portal accounts.

1.5   How do I view my Revalidation status?

To view your status:

1. Go to the TMHP website at www.tmhp.com.

2. Log into My Account.

3. Select Provider Information Management System (PIMS), which is located under "Manage Provider Accounts."

4. The PIMS Administrator Screen will display "Revalidation Date" for each National Provider Identifier (NPI), Atypical Provider Identifier (API) or TPI numbers attached to one account.

5. You can also click on any of the listed NPIs to go to the PIMS information Change Screen. The PIMS Information Change Screen will also display "Revalidation Date."

1.6   I have several TPIs. Do I need to revalidate each TPI separately, or can I revalidate them together?

PEP allows users to select multiple performing, individual, and ordering/referring TPIs for revalidation simultaneously, based on several factors such as revalidation due date, the NPI, License Number, risk level, primary TPI selected, and more that is listed on the user account. For user accounts which manage multiple providers, this can help minimize the amount of time spent on application entries, possible confusion about revalidation timelines, and streamlines the revalidation process across multiple providers. It is highly recommended that users take full advantage of this feature whenever possible.

1.7   What do I do if I need to update my demographic information?

If you are an existing provider, review and update your demographic information in the Provider Information Management System (PIMS) through My Account. We can't process your revalidation application until we have your updated information. Visit the Provider Information Management System (PIMS) to review and submit updates to your Demographics and Enrollment Information prior to beginning your revalidation application.

Changes to your information can take up to 30 business days to process.

1.8   How often will I need to revalidate?

All providers are required to revalidate enrollment information every three or five years based on provider type. For more information, please see Section 2. In some situations, in compliance with TAC §371.1015, providers may have to revalidate enrollment on a more frequent basis.

1.9   What happens if I encounter problems during online Revalidation and must begin the process again? Is there a limit to the number of times I may initiate Revalidation?

Only one revalidation or re-enrollment application can be in progress at any given time. For example, if the user accidentally begins a re-enrollment application, but meant to begin a revalidation application, they must then cancel the existing re-enrollment application on the Existing Transaction page in PEP, before they are able to begin a revalidation application for the same TPI.

TMHP has Provider Relations representatives that can assist with your revalidation needs. You can access a TMHP provider relations representative by calling the TMHP Contact Center at **1-800-925-9126** or the TMHP–CSHCN Services Program Contact Center at **1-800-568-2413** Monday through Friday from 7 a.m. to 7 p.m.

1.10   How long does it take to process a re-enrollment application or revalidation application?

It takes up to 60 business days to process the enrollment application once TMHP has received all of the information that is necessary to process it. It may take longer in special circumstances.

1.11   Is there any way to expedite the application review process?

No. Applications are worked in the order in which they are received. Texas Medicaid is committed to avoiding any unnecessarily lengthy periods of time for completing the provider screening and application process.

1.12   If my Revalidation application is not finalized by the due date, will my claims and authorizations be impacted?

Yes. If you don't complete the revalidation process by the due date, you will be disenrolled from all Texas state health-care programs, including MCOs and DMOs and your claims and prior authorization requests will be denied.

1.13   What happens if I miss my revalidation due date?

If you have not submitted your application by the revalidation due date you will be disenrolled and you will have to submit a re-enrollment application.

1.14   When completing the revalidation application, the information provided will replace the old application, correct? Is there a way to review what the current information is that's on the application if it's not on or in PEP?

The revalidation information will replace the old application. Providers are encouraged to retain all application documentation.

1.15   What are the advantages of using PEP?

PEP guides applicants through the enrollment process and can help you complete the application more accurately by doing the following:

- Applications are validated immediately to ensure that all fields have been completed.
- Most of the application can be completed online so that only a few forms need to be printed, completed, and attached via PEP.
- Applicants can view both incomplete and complete applications that have been submitted online.
- Some form fields are automatically completed, reducing the amount of information that has to be entered.
- Providers will receive email notifications when messages or deficiency notices about their applications are posted online in PEP. The messages can be viewed on the secured access portion of the website.
- Providers may opt out of email communication and receive messages or deficiency letters by mail.
- Providers can create templates, which make it easier to submit multiple enrollment applications.
- Providers who enroll as a group can assign portions of the application to performing providers to complete. Performing providers can complete their portion of a group application by logging into the online PEP tool with their unique user names and passwords.
- Providers can navigate to completed sections of the application without having to click through all pages of the application.

- Information that is on file for owners and subcontractors of the applying provider are auto-populated in the application.

Enrolling online promotes accurate submissions, decreases processing time, and enables immediate feedback on the status of the application.

1.16   How can providers get started on PEP?

Visit the TMHP website at www.tmhp.com, and click on the "Not yet a provider?" web ad on the right side of the page. On the next page, click on the "I would like to…" link at the top right of the page. On the following page, click the "Activate my account (Provider Enrollment on the Portal [PEP]) link."

2.1 How and why are providers categorized by risk?

The Centers for Medicare & Medicaid Services (CMS) requires states to screen all initial enrollment, revalidation, and re-enrollment applications on a categorical risk level. CMS has defined three levels of risk: limited, moderate, and high. Provider types are assigned to each category based on an assessment of the risk of fraud, waste, and abuse.

2.2 Which types of providers are included in each risk category?

The following table shows the provider types for each risk category:

Provider Type Risk Categories			
Limited Risk			
• Physicians • Non-physician practitioners • Medical groups and clinics • Ambulatory surgical centers (ASCs) • Audiologists	• Federally qualified health centers (FQHC) • Hospitals, including critical access hospitals • Indian and Tribal Health Services facilities	• End stage renal disease facilities • Mass immunization roster billers • Occupational therapists enrolling as individuals or as group practices	• Pharmacies • Radiation therapy centers • Rural health clinics (RHC) • Skilled nursing facilities • Speech language pathologists
Moderate Risk			
• Ambulance service suppliers • Community mental health centers • Outpatient rehabilitation facilities	• Independent clinical laboratories • Independent diagnostic testing facilities • Hospice organizations (CSHCN Services Program only)	• Physical therapists enrolling as individuals or as group practices • Portable X-ray suppliers • Currently enrolled (re-enrolling) home health agencies	• Currently enrolled (re-enrolling) DMEPOS providers • Comprehensive outpatient rehabilitation facilities

Provider Type Risk Categories	
High Risk	
• Prospective (newly enrolling and re-enrolling) home health agencies	• Prospective (newly enrolling and re-enrolling) DMEPOS providers
• Opioid Treatment Providers (OTP)	• State Supported Living Centers (SSLC)
• Hearing Aid – Fitter/Dispensers	• Pharmacy (CCP) DME
• Prescribed Pediatric Extended Care Center	• Custom Wheeled Mobility

2.3 Why is my risk category different than what is listed in the table above?

Beginning July 1, 2018, in accordance with 42 CFR §455.450, TMHP began adjusting the Screen Risk Category from Limited or Moderate to High for providers that meet the following conditions:

- The provider has an existing Medicaid overpayment, further defined in the Medicaid Provider Enrollment Compendium (MPEC) as:

  Aggregate of all outstanding debt is over $1500

  More than 30 days old

  Has not been repaid prior to the submission of an enrollment application

  Is not currently being appealed

  Is not part of a state medicaid agency-approved extended repayment schedule for the entire amount of the outstanding debt
- The provider has been excluded by the HHS or HHSC Office of the Inspector General or another state's Medicaid program within the last 10 years.
- The provider has had a payment hold for a credible allegation of fraud within the last 10 years.
- The provider meets the requirements for a provider enrollment moratorium that has been lifted within the past 6 months.

The adjustment in Screen Risk Category will occur when an enrollment or revalidation application has been submitted. The reason for the adjustment in Screen Risk Category is displayed on the PIMS landing page once the enrollment process has been completed. Claims processing will not be affected by this update.

Affected providers can refer to the CMS website for specifics of conditions for the Limited, Moderate and High Risk Level categories. Providers can also refer to 42 CFR §455.450.

2.4   How does my risk category affect my Revalidation?

The screening activities are determined based on the screen risk category.

The following table shows the screening activities required for each risk category:

Risk	Screening Activities
Limited	Verification of provider-specific requirements, including but not limited to the following: • Verify a provider meets all state and federal requirements for the enrolling provider type • License verification, including state licensure in states other than where the provider is enrolling • Federal and state database checks
Moderate	• All screening activities for limited risk providers • Pre-enrollment and post-enrollment site visits at initial enrollment, re-enrollment, and revalidation
High	• All screening activities for limited and moderate risk providers • Fingerprint-based Criminal Background Check for all providers and associated owners with 5 percent or more direct or indirect ownership Proof of fingerprinting must be submitted for each individual meeting this requirement. Refer to Texas Medicaid Provider Fingerprinting Requirement FAQ

Section 3: Provider Screening

3.1 Is provider screening a new requirement?

No, provider screening is not a new requirement. TMHP and HHSC have always performed screening activities that include license verification and criminal history checks.

Please refer to the table in Section 2 of this document for the screening activities associated with each risk category.

3.2 Who am I required to disclose?

The Provider Information Form (PIF-1) must be completed by, or on behalf of, the provider that is applying for enrollment. If the provider is an entity, the PIF-1 must be completed on behalf of the entity.

The Principal Information Form (PIF-2) must be completed for a person or entity that meets the definition of a "Principal" or "Subcontractor" as defined as below:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.
- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies.

3.3   For Medicare enrolled providers, what ownership information must match Medicare and the Texas Medicaid application?

For the enrolling provider, name, practice location, NPI, social security number must match Medicare and Texas Medicaid enrollment application.

For a person or entity that meets the definition of a "Principal" or "Subcontractor" as defined above in question 3.2, the name, practice location, social security number (if applicable), Tax identifier number (TIN) (if applicable), and percentage of ownership must match.

3.4   What are the guidelines or requirements for submitting the fingerprint submissions for providers and owners?

For information related to the submission of fingerprints for all high-risk providers, refer to the Texas Medicaid Provider Fingerprinting Requirement Frequently Asked Questions that is located on the Provider Enrollment page of TMHP.com.

3.5   If I have already been surveyed by a Licensure Survey for the year, will this suffice for the site visit?

No, the pre-enrollment and post-enrollment site visits as detailed in 42 CFR §455.432 are required of providers who are designated as "moderate" or "high" risk. This requirement is separate from Licensure Survey Requirements.

3.6   How long are the site visits?

The length of the site visits will differ from provider to provider.

3.7   What is the purpose of a site visit?

The purpose of the site visit is to verify that the information submitted to the State Medicaid Agency (SMA) is accurate and to determine compliance with federal and state enrollment requirements. (§455.432(a))

Section 4:   Application Fee

Texas Medicaid must comply with 42 CFR §455.460, which requires an application fee for institutional providers. CMS defines an institutional provider as any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (but not physician and non-physician practitioner organizations), or CMS-855S or associated internet-based PECOS enrollment application.

4.1   How much is the application fee?

The amount of the application fee is subject to change every calendar year. Each year, CMS will publish the application fee in the Federal Register 60 days prior to the new calendar year. The fee for calendar year 2022 is $631.00.

4.2   Who needs to pay the application fee?

The application fee is required for any newly enrolling, re-enrolling, or revalidating "institutional provider," including providers that are applying for a new practice location as defined in 42 CFR §455.460. Please refer to 1 TAC §352.7 for more information about the application fee.

> **Note**: *Physicians and non-physician providers are not required to pay the application fee. This includes physicians and non-physician practitioners in medical groups and clinics.*

To determine if your provider type is required to pay the application fee, refer to the State of Texas Provider Types Required to Pay an Application Fee Matrix available at on the TMHP website.

4.3   All of my providers are under one TPI. Is the fee for each individual provider or by TPI?

The application fee is required and due at the time of submission for each initial enrollment, re-enrollment, and revalidation application submitted to Texas Medicaid.

4.4   I paid a fee when I re-credentialed my license with Department of Aging and Disability Services (DADS). Do I have to pay another application fee?

Yes. The fee that was paid for DADS re-credentialing is separate from the ACA required application fee. The application fee applies to any newly enrolling, re-enrolling, or revalidating institutional provider, including providers that are applying for a new practice location as defined in 42 CFR §455.460. Providers can refer to 1 TAC §352.7 for more information about the application fee.

4.5   I have submitted an application to Texas Medicaid, but I cannot afford the new application fee at this time. What do I do?

Consistent with Medicare payment guidance in 42 CFR §424.514 related to application fees, Texas Medicaid will allow providers to submit a request for a hardship exception waiving the application fee. The provider must submit a letter with the enrollment, re-enrollment, or revalidation application that explains the request for the hardship exception and include supporting documentation (i.e., historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.). HHSC will confer with CMS on the final decision to approve or deny the hardship exception request.

Providers that are enrolled in Medicare or another state's Medicaid or CHIP program and that were granted a hardship exception must still request a hardship exception from Texas Medicaid per submitted application. The hardship exception will only be valid during the current enrollment period.

4.6   If a physician is also enrolled as a DME provider, is an application fee required?

The application fee is only required for the durable medical equipment (DME) enrollment. Physician and non-physician practitioner providers are excluded from the application fee requirement.

4.7   If I use PEP to submit an application, do I need to mail the application fee payment before or after the online submission is complete?

TMHP recommends mailing the payment after the online TMHP PEP submission is complete, so that the payment is applied appropriately.

Include the Portal Ticket Number on the check and print the PEP Cover letter. Mail the printed PEP Cover letter with the check.

4.8   Is it true that Children with Special Health Care Needs (CSHCN) Services Program Hospice and Medical Foods providers must submit paper applications for revalidation and have no application fees? What about other provider types that can enroll into CSHCN Services Program?

Yes, hospice and medical foods providers must submit the paper CSHCN Services Program Provider Enrollment Application to revalidate. No application fee is required.

All other CSHCN Services Program providers are automatically revalidated according to the status of their related Traditional Medicaid enrollment and do not need to submit an application.

Section 5:   Compliance Programs

5.1   What is a Compliance Program?

According to CMS, and as defined by the United States Sentencing Commission (USSC), a compliance program is a program designed to prevent and detect criminal conduct. Further, compliance efforts are fundamentally designed to establish a culture within an organization that promotes the prevention, detection, and resolution of conduct that does not conform to federal and state law or to federal health-care program requirements.

5.2   Am I required to have a Compliance Program as specified in TAC §352.5(b)(11)?

A enrolling, re-enrolling, or revalidating provider must certify that it has a compliance program containing the core elements as established by the Secretary of Health and Human Services referenced in §1866(j)(8) of the Social Security Act (42 U.S.C. §1395cc(j)(8)), as applicable.

5.3   What are the core elements of an effective Compliance Programs referenced in TAC §352.5(b)(11)?

According to CMS by way of the ACA, the elements described by the USSC are used as the basis for the core elements of the required compliance programs for Medicare, Medicaid, and CHIP enrollment. Although compliance programs may differ between organizations based upon the type or specialty of the services provided, according to CMS, an effective compliance program includes the following:

- The development and distribution of written policies, procedures, and standards of conduct to prevent and detect inappropriate behavior;
- The designation of a chief compliance officer and other appropriate bodies (for example a corporate compliance committee) that are charged with the responsibility of operating and monitoring the compliance program and who report directly to high-level personnel and the governing body;
- The use of reasonable efforts not to include any individual in the substantial authority personnel whom the organization knew, or should have known, has engaged in illegal activities or other conduct inconsistent with an effective compliance and ethics program;
- The development and implementation of regular, effective education and training programs for the governing body, all employees, including high-level personnel, and, as appropriate, the organization's agents;
- The maintenance of a process, such as a hotline, to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;
- The development of a system to respond to allegations of improper conduct and the enforcement of appropriate disciplinary action against employees who have

violated internal compliance policies, applicable statutes, regulations, or federal health-care program requirements;

- The use of audits or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas;

- The investigation and remediation of identified systemic problems, including making any necessary modifications to the organization's compliance and ethics.