§ 108C-3. Medicaid provider screening.

(a) Provider Screening. – The Department shall conduct provider screening of Medicaid providers in accordance with applicable State or federal law or regulation.

(b) Enrollment Screening. – The Department must screen all initial provider applications for enrollment in Medicaid, including applications for a new practice location, and all revalidation requests based on Department assessment of risk and assignment of the provider to a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(c) Limited Categorical Risk Provider Types. – The following provider types are hereby designated as "limited" categorical risk:

(1) Ambulatory surgical centers.

(1a) Behavioral health and intellectual and developmental disability provider agencies that are nationally accredited by an entity approved by the Secretary.

(2) End-stage renal disease facilities.

(3) Federally qualified health centers.

(4) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.

(5) Histocompatibility laboratories.

(6) Hospitals, including critical access hospitals, Department of Veterans Affairs Hospitals, and other State or federally owned hospital facilities.

(6a) Licensed outpatient behavioral health providers.

(7) Local Education Agencies.

(8) Mammography screening centers.

(9) Mass immunization roster billers.

(10) Nursing facilities, including Intermediate Care Facilities for Individuals with Intellectual Disabilities.

(11) Organ procurement organizations.

(12) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, and audiologists), optometrists, dentists and orthodontists, and medical groups or clinics.

(13) Radiation therapy centers.

(14) Rural health clinics.

(15) Hearing aid dealers.

(16) Portable X-ray suppliers.

(17) Religious nonmedical health care institutions.

(18) Registered dieticians.

(19) Clearinghouses, billing agents, and alternate payees.

(20) Local health departments.

(d) When the Department designates a provider as a "limited" categorical level of risk, the Department shall conduct such screening functions as required by federal law.

(e) Moderate Categorical Risk Provider Types. – The following provider types are hereby designated as "moderate" categorical risk:

(1) Ambulance services.

(2) Comprehensive outpatient rehabilitation facilities.

(3) Repealed by Session Laws 2018-5, s. 11H.12(a), effective June 12, 2018.

(4) Repealed by Session Laws 2013-378, s. 6, effective October 1, 2013.

(5) Hospice organizations.
(6) Independent clinical laboratories.
(7) Independent diagnostic testing facilities.
(8) Pharmacy Services.
(9) Physical therapists enrolling as individuals or as group practices.
(10) Revalidating adult care homes delivering Medicaid-reimbursed services.
(11) Revalidating agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.
(12) Revalidating agencies providing nonbehavioral health home- or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
(13) Revalidating agencies providing private duty nursing, home health, personal care services or in-home care services, or home infusion.
(14) Nonemergency medical transportation.

(f) When the Department designates a provider as a "moderate"' categorical level of risk, the Department shall conduct such screening functions as required by federal law and regulation.

(g) High Categorical Risk Provider Types. – The following provider types are hereby designated as "high" categorical risk:

(1) Prospective (newly enrolling) adult care homes delivering Medicaid-reimbursed services.
(2) Agencies providing behavioral health services, excluding (i) behavioral health and intellectual and developmental disability provider agencies that are nationally accredited by an entity approved by the Secretary and (ii) licensed outpatient behavioral health providers.
(3) Repealed by Session Laws 2018-5, s. 11H.12(a), effective June 12, 2018.
(4) Prospective (newly enrolling) agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.
(5) Agencies providing HIV case management.
(6) Prospective (newly enrolling) agencies providing nonbehavioral health home- or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
(7) Prospective (newly enrolling) agencies providing personal care services or in-home care services.
(8) Prospective (newly enrolling) agencies providing private duty nursing, home health, or home infusion.
(9) Providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the cessation of the payment suspension.
(10) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General, the Medicare program, or another state's Medicaid or Children's Health Insurance Program within the previous 10 years.
(11) Providers who have incurred a Medicaid final overpayment, assessment, or fine to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid in the previous 12-month period. The Department shall return the provider to its original risk category not later than

12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine.

(12) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-4 but were granted an exemption by the Department within the previous 10 years.

(h) When the Department designates a provider as a "high" categorical level of risk, the Department shall conduct such screening functions as required by federal law and regulation.

(i) For providers dually enrolled in the federal Medicare program and Medicaid, the Department may rely on the results of the provider screening performed by Medicare contractors.

(j) For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Children's Health Insurance Program agencies of other states. (2011-399, s. 1; 2013-378, s. 6; 2016-94, s. 12H.3(a); 2018-5, s. 11H.12(a); 2022-74, s. 9D.15(z).)