Policy and Procedure		
SUBJECT: Excluded Providers and Individuals Policy	DEPARTMENT: **Regulatory Compliance, Risk Management and Government Affairs**	
ORIGINAL EFFECTIVE DATE: **08/10**	DATE(S) REVIEWED/REVISED: 11/10, 08/11, 05/12, 10/12, 05/13, 04/14, 04/15, 04/16, 04/17, 04/18, 07/19, 07/21, 05/22, 10/23, 09/24, 11/25	
APPROVED BY: Chief Compliance and Risk Officer	NUMBER: **RA 49**	PAGE: **1 of 9**

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange ☐ Oregon Off Exchange ☐ Washington Off Exchange	☐ Oregon On Exchange (SHOP) ☐ Oregon Off Exchange (SHOP)	☐ Oregon ☐ Washington	☐ ASO ☐ PBM	☐ Medicare	☐ Medicaid
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:
In accordance with Federal law Companies do not pay for services, equipment or drugs prescribed or provided by a provider or supplier excluded by the Health and Human Services Office of the Inspector General (HHS OIG) LEIE exclusion lists, or the EPLS found on the System for Award Management (SAM) debarment lists. Company reviews both lists prior to hiring or contracting with a new employee, temporary employee, volunteer, consultant, governing body, member, or all First Tier, Downstream, and Related Entities (FDR). Company checks the LEIE and EPLS monthly to ensure that none of these entities are excluded or become excluded from participation in Federal programs. For Medicare lines of business, the company also monitors the Preclusion list and ensures individuals on this list do not receive or retain payments. Additionally, the Department of Treasury's Office of Foreign Assets Control (OFAC) prohibits all US persons from dealing with "Specially Designated Nationals" or "SDNs." This policy outlines the guidelines regarding Sanctioned Providers and SDNs and the steps that Company takes in order to be compliant with these regulations.

Companies are responsible for ensuring that:

I. No payments are made to those providers (individuals and other businesses) sanctioned by the OIG; and

II. Sanctioned providers (individual and other businesses) are not enrolled in the Company Medicare Network.

Companies have a process to perform claims audits and stop payment based on the Sanctioned Provider list to ensure that those providers (individuals and other businesses) are not receiving payment. This list is updated monthly by OIG and is monitored by Company monthly.

Indictment of a provider or supplier does not constitute program exclusion. Formal conviction or inclusion in the OIG list would be confirmed before payment may be stopped under this policy.

The OIG prohibits Medicare Advantage Plans from issuing payments to those providers excluded by the Medicare/Medicaid Program and/or sanctioned by the OIG.

The Preclusion list is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Providers will be found on the preclusion list if they:

Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
OR
Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

CMS made the Preclusion List available to Part D sponsors and the MA plans beginning JANUARY 1, 2019. EFFECTIVE APRIL 1, 2019 and after:

- Part D sponsors will be required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.
- MA plans will be required to deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

DEFINITIONS:

A Sanctioned Provider (individual or business) is one that is excluded from participation for a stated period of time from the Federal Medicare/Medicaid Program as a result of a fraudulent activity/program abuse or impermissible conduct as determined by the OIG. A Sanctioned Provider has the right to appeal his/her sanctioned status through the Departmental Grants Appeals Board.

A provider, individual or business may be sanctioned by the OIG based on Mandatory or Permissive Exclusions as follows:

Mandatory exclusions indicate automatic reasons for a provider to be excluded from participation in any Federal health care program. The following is a list of mandatory exclusions:

- Conviction of a criminal offense related to the delivery of an item or service under Medicare or a State health care program.
- Conviction, under Federal or State law, of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that the OIG concludes entailed, or resulted in, neglect or abuse of patients.
- Conviction, under Federal or State law, of a felony that occurred after August 21,1996 related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other misconduct.
- Conviction, under Federal or State law, of a felony that occurred after August 21,1996 related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as defined under Federal or State law.

Permissive Exclusions indicate reasons under which a provider may be excluded from participation in any Federal health care program. The following list includes, but is not limited to, permissive reasons for exclusion:

- A misdemeanor related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct within a health care program.
- Fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct with respect to any act or omission is a program, other than a health care program, operated by or financed in whole or in part by any Federal, State or local government agency.
- Conviction under Federal or State law, in connection with the interference with or obstruction of any investigation into a criminal offense.
- Conviction under Federal or State law of a misdemeanor related to the unlawful manufacture, distribution, and prescription or dispensing of a controlled substance.
- License to provide health care revoked or suspended by any State licensing authority, or otherwise lost such license (including the right to apply for or renew such a license), for reasons bearing on the individual's or entity's professional competence, professional performance or financial integrity.

- Exclusion or suspension from participation in any Federal health care program involving the provision of health care or a State health care program, for reasons bearing on the individuals or entity's professional performance or financial integrity.
- Submission of claims for excessive charges or unnecessary services or failure to furnish medically necessary services.
- Maintaining a relationship with an excluded provider, who has been convicted of a criminal offense, has had civil money penalties or assessments imposed, or has been excluded from participation in Medicare or any of the State health care programs. Such person includes the following:
    - Has direct/indirect ownership interest of 5% or more in the entity, or
    - Is the owner in whole or part interest in any mortgage, deed of trust or other note secured by the entity, or
    - Is an officer or director of the entity, or
    - Is an agent (any person who has express or implied authority to obligate or act on behalf of an entity), or
    - Is a managing employee (including a general manager, business manager, administrator or director) who exercises operation or managerial control over the entity?
- Failure to provide payment information that is requested to determine whether such payments are or were due.
- Failure to grant immediate access upon reasonable access to records to perform reviews and surveys, to exam performance of the statutory functions and for the purpose of conducting activities related to the fraud control unit.
- Failure to comply with a corrective action plan.
- Default on a health education loan or scholarship obligations.

Specially Designated Nationals include countries and groups of individuals, such as terrorists and narcotics traffickers who are subject to economic sanctions programs administered and enforced by OFAC.

PROCEDURE AND RESPONSIBILITIES:

The Secretary of the Department of Health and Human Services (DHHS) has delegated to the OIG the authority to exclude various health care providers, individuals and businesses from receiving payment for services that would otherwise be payable under the Federal Medicare/Medicaid Program.

When exclusion is imposed, no payment may be made to anyone for any items or services** (Refer to exceptions below) furnished, ordered, or prescribed by an excluded party under the Medicare Program.

- This means that no payment is made to any supplier (e.g., DME) that submits bills for payment of items or services provided, ordered, prescribed, or referred to by an excluded provider.
- Also, payment under any State health care program is prohibited.

In addition to a sanctioned provider or individual, payment may not be made to a business or organizational providers (e.g., a hospital that submits bills for payment of items or services provided, ordered, prescribed, or referred by an excluded party).

Note: "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual or ordered or prescribed by a physician (either as an employee or in their own capacity), a provider or other supplier of services.

Notification

- The OIG sends a notice concurrently to the excluded provider, the Medicare Advantage Plan, the State Agency administering or supervising the administration of each State health care program, the PRO and the RRB.
- The OIG also notifies the appropriate licensing agency, the public, and all known employers of the sanctioned provider.
- The OIG provides monthly as well as quarterly summaries of those providers who have been sanctioned or if the sanction is lifted under the Medicare Program.
- Credentialing monitors licensing boards and credentialing information in relevant states for sanctions, actions or excluded providers.
- CMS will publish the Preclusion List monthly starting January 1 2019. PHP will monitor this list monthly.

State of Emergency **EXCEPTION when applicable.**

Emergency items or emergency services provided by a Sanctioned individual who does not routinely provide emergency health care items or services may be reimbursed (i.e., those providers that do not have a specialty in Emergency Medicine). Excluded physicians employed by a hospital will not be paid.

Denial of Payment when submitted by the Excluded Provider

Company makes no payment for items or services furnished, ordered or prescribed on or after the effective date of exclusion, except for the following cases:

1. For inpatient hospital services or post-hospital SNF care provided to an individual admitted to a hospital or SNF before the effective date of the exclusion, make payment, if appropriate, for up

to 30 days after the date of exclusion; and

2. For home health services provided under a plan established before the effective date of exclusion, make payment, if appropriate, for 30 days after the date of exclusion.
    a. Payment is made to an excluded provider for emergency items and services furnished, ordered or prescribed, unless they are Emergency Services specialists; or
    b. Hospital Emergency Room Staff.

Those claims that are received from and identified as Sanctioned Providers, as determined by the OIG, are to be denied using the appropriate denial code that states CMS does not permit payment and balance billing is prohibited.

Denial of Payment to Members and Suppliers

If Company receives a claim from member or a non-sanctioned supplier for items or services (e.g., pharmaceutical or DME) furnished, ordered or prescribed by a Sanctioned Provider after the date of exclusion:

1. Payment is made for the first claim submitted and a letter is sent giving the member and supplier notice of the exclusion.
2. Thereafter, payment will not be made to the member or supplier for items or services provided by an excluded party more than 20 days after the date of the notice to the member/supplier or after the date of exclusion, whichever is later.

OFAC Review:

Companies have a process for an annual comparison of all members and employer groups against the OFAC SDN list. Should any SDNs be identified, Company will contact OFAC and work with them to determine the appropriate course of action, which could include termination of policy, per OFAC instructions.

DEPARTMENTAL PROCEDURES:

IT Department

IT Designee searches OIG exclusion list, EPLS list, Preclusion List and other lists as required for an updated file. When file appears, runs data against current provider/facility network database. (See System Administration Policy 38.0 Excluded Providers) The results of the data run are forwarded to a shared folder and an automatic alert is activated.

The automatic alert will be sent to the **Director Medicare Compliance, Special Investigations Unit (SIU) Director of Payment Integrity, Credentialing Supervisor, Pharmacy Coordinator Compliance/Product Management, Credentialing Coordinator, Manager of Provider Relations, Manager of Contracting and System Administration Manager. Preclusion list notification is sent to SIU Data Analyst.**

Credentialing

Credentialing monitors Medicare and Medicaid sanctions within 30 days of receiving OIG exclusion, EPLS, and Preclusion lists. (See Credentialing Services Policy CR 9.0 Ongoing Monitoring, Corrective Action, and Intervention) In the event a credentialed practitioner or organizational provider is found to be on any sanction or exclusion report, Provider Relations will be notified to term all Medicare/Medicaid products immediately.

Pharmacy

Pharmacy Coordinator of Compliance and Product Management and **Pharmacy Quality and Utilization Management Business Analyst** receive HPMS memo alerts of excluded providers. If provider noted, pharmacy notifies member of excluded provider and requests they cease receiving services or supplies from the excluded provider.

SIU

SIU External Audit Data Analyst analyzes name of both participating and non-participating precluded and excluded providers against claims payment data base. SIU will request source documents to complete investigation, if not sent. After investigation, SIU will request pend to review precluded and excluded providers claims pre-payment. If providers have sanction or action on their license, but are not excluded they may be entered as a new SIU case for triage, but will not be pended. SIU also seeks recovery on any claims paid to precluded or excluded providers paid after exclusion. SIU notifies PH Tech of any new providers on precluded and excluded provider lists with Oregon Health Plan exposure. SIU Data Analyst forwards the confirmed Precluded and Excluded provider list to key stakeholders in process.

PH Tech

PH Tech evaluates SAMS and OIG lists against their list of non-par providers through their external vendor on a timely basis. If any paid claims to a non-par excluded provider within the past month are found, PH Tech notifies SIU.

System Administration If a provider is found in the claims system (FACETS), SIU will submit a JAMA ticket to the System Administration team on the provider in order to flag future claims for review by the SIU, per policy SAP 67.00 SIU Pend Process Excluded/ Sanctioned Providers.

Provider Contracting

Manager of Provider Contracting notes excluded providers and reviews contracts accordingly.

Office Services

Office services receives confirmed preclusion list and initiates process to notify the beneficiary "as soon as possible but not later than 30 days from the posting of the list" and the beneficiary should have "at least 60 days' advance notice" before the plan denies payment/rejects claims associated with the precluded provider. This period will allow the beneficiary at least 60 days to find a new provider and obtain a new prescription.

OFAC Reporting

IT will run an annual report at the end of each year comparing the OFAC list to Facets. The report will search for matches on employer group names and member name and date of birth, excluding members and groups with the "CUBA" designation. Once this report is complete, an email alert will be sent to Membership Accounting and Regulatory Compliance and Government Affairs. Membership Accounting will notify Regulatory Compliance, Risk Management and Government Affairs if there are no matches on the report. If there are matches, Membership Accounting will investigate and verify them and notate the results on the report. Membership Accounting will send the verified report with comments to Regulatory Compliance, Risk Management and Government Affairs for follow up action.

Procedure for correcting inappropriate exclusion denials

Every effort will be made to accurately verify the identity of the excluded entity/provider and the corresponding match of an entity/provider in our systems. If a provider or other billing entity is excluded and later it is found that this exclusion decision was made in error, Company will correct the error using a process that may include but is not limited to the following steps to correct inappropriate exclusion denials:

1. Search records and systems for denied claims.
2. Remove applicable restrictions, pends or edits to ensure that prospective claims will not be inappropriately denied due to exclusion error. This must be completed within 24 hours of notification by Medicare, CMS or the provider.
3. For past denied claims, identify and reprocess claims. Retrospective claims must be rectified within 24 hours of notification as well.
4. Contact beneficiaries to inform them of their plan sponsor's error within 7 calendar days. **NOTE: The included model retraction letter should be used for this purpose.**
5. Send a list of all affected beneficiaries to the CMS Account Manager within 7 calendar days.

REFERENCES:

MMCM, Chapters 6 and 21
PDBM, Chapter 9,
Federal Register, §438.214 and §438.610, 42 CFR §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F),
42 CFR 1001.1901, §1128 and §1128A
Balanced Budget Act, Subtitle D. "Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity"
System Administration Policy 38.0 Excluded Providers
CR 9.0 Ongoing Monitoring, Corrective Action, and Intervention
SAP 67.00 SIU Pend Process Excluded/ Sanctioned Providers