

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR PROGRAM INTEGRITY
CENTER FOR MEDICARE

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TO: Medicare Advantage Organizations
Part D Sponsors
Program of All-Inclusive Care for the Elderly (PACE)

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SUBJECT: Excluded Providers

It has come to CMS' attention that problems are occurring in the implementation of the prohibition against making payments for items or services furnished by an excluded provider or entity or for a prescription written by an excluded provider. [See §1862(e)(1) of the Social Security Act which is codified in Title 42 of the Federal Regulations at §422.204(b)(4), §422.752(a)(8), and §423.752(a)(6).]

- Some Prescription Drug Plan Sponsors or their downstream entities are rejecting pharmacy claims inappropriately. This typically happens when a prescriber is misidentified at the claims processing level as being excluded.
Example: A prescribing provider has the same name as an excluded provider, but is not the excluded provider.
- Many Medicare Advantage Organizations (MAO), PACE Organizations, and Prescription Drug Plan (PDP) Sponsors are not prohibiting payments to excluded providers or entities through timely review of the List of Excluded Individuals and Entities posted on the Office of Inspector General's website. This issue was a frequent audit finding in 2010.

To assist MAOs, PACE Organizations, and PDP Sponsors in identifying excluded providers, CMS will send Medicare Exclusion Database (MED) files to plan sponsors each month. The source of the MED files is the OIG List of Excluded Individuals and Entities. Additional information that is not available on the OIG List of Excluded Individuals and Entities, including the National Provider Identifier (NPI) is added by CMS. The MED is to be used as another tool to assist plan sponsors in identifying an excluded individual or entity; it is not intended to replace

processes and procedures that all plan sponsors are responsible for developing to ensure compliance with statutory and regulatory requirements. It is expected that CMS will make the MED file available in the late summer. Instructions for receiving the file will be provided by the Center for Program Integrity closer to the release date of the MED.

In addition to the MED, CMS will also provide information regarding OIG-granted waivers to exclusions and immediate or retroactive reinstatements. An excluded provider may have a partial waiver to his/her exclusion at specific practice locations. CMS will share this information with plan sponsors as we become aware of it. This information will be shared through the CMS Account Manager. Once notified, the plan sponsor is required to remedy any error.

Procedure for correcting inappropriate exclusion denials

Plan sponsors are accountable for ensuring correct implementation of exclusion information and no delay in access to care due to errors in claims processing or editing systems. Inappropriate exclusion denials cannot be resolved by the OIG or CMS. Plan sponsors are expected to effectuate changes in their system without delay after receiving information regarding the error from either the CMS Account Manager or the provider. Until the MED file is released sponsors may want to cross-reference the National Plan & Provider Enumeration System website (NPPES), <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, when complaints about inappropriate denials are received directly from providers.

Sponsors should take the following steps to correct inappropriate exclusion denials:

1. Search records and systems for denied claims.
2. Remove applicable restrictions 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 the Account Manager or the provider.
3. For past denied claims, contact pharmacies to have claims reprocessed. 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 attached 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.

Any complaints the Agency receives about inappropriate exclusion edits will be considered an access to care issue and will be recorded in CTM for handling as an immediate need. Continued problems with inappropriate exclusion edits and prescription denials may lead to compliance action. Questions concerning this memorandum should be directed to your CMS Account Manager.

Attachment