# Exclusions vs. Preclusions

Insights, analytics, and monitoring best practices after one year of releases.

Say hello to today's presenters.

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Today's Agenda:

1. The current state of the **preclusion**

2. The current state of the **exclusion**

3. Insights, analytics, and **understanding the gaps**

4. Best practices & monitoring recommendations

5. Key takeaways

Understanding the Preclusion List.

The good, the bad, and the messy.

What is the Preclusion List?

The **Preclusion List** is comprised of any individual or entity that meets the following criteria:

- Is **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.

Preclusion List Basics:

CMS makes the Preclusion List available to the Medicare Advantage (MA) plans and Part D plans.

MA plans will deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

Part D plans will 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.

*Note: CMS precludes individuals and entities at the Tax Identification Number (TIN) level. Therefore, individuals and entities will not appear on the preclusion list unless **ALL** Medicare enrollments under their TIN are revoked or inactive.*

General Preclusion List Questions

- Are **Part D** prescribers and providers participating in Medicare Advantage (MA) **required** to enroll in Medicare?

- How will a provider know if they are on the Preclusion List?

- What is the length of time a provider can expect to be on the Preclusion List?

- In regards to dual members who see a precluded provider, who becomes the primary payer? Is the plan to follow standard coordination of benefits guidance?

- Will Precluded Providers also be precluded from being paid for services to Medicaid members?

Does the list apply to you?

Are you a **Medicare Advantage Plan**?
Are you an **1876 Cost plan**?
Are you a "**Programs of All-Inclusive Care for the Elderly**" Program?
Are you a **Medicare Advantage Part D Plan**?

No

According to the CMS Memorandum dated **November 2, 2018**, it appears you may not meet the definition of those organizations required to monitor the Preclusion List. (**CMS Provider Information**) The ProviderTrust team is happy to discuss your Preclusion List analysis and monitoring needs. Contact us at **(615) 938-7878**.

Yes

Do you currently have a **CMS Enterprise Identity Data Management** (EIDM) Account?

(Note: EIDM is the system that connects you to all of the CMS applications)

No

Click this link to access the **Preclusion List User Reference Guide** for instructions on how to sign up for an EIDM user ID.

Yes

Have you requested access to the **CMS Preclusion List**?

No

Click this link to access the **Preclusion List User Reference Guide** for instructions on how to request access to the Preclusion List

Yes

Have you downloaded the **CMS Preclusion List?**

No

Click this link to access the **Preclusion List User Reference Guide** for instructions on how to download the Preclusion List.

Yes

Congratulations, you are ready to monitor the Preclusion List!

Member impact and how to operationalize.

Member Impact

How are members notified?

How will the **provider's inclusion** on the Preclusion List impact a member's ability to:

- Appeal a subsequent claim denial or rejection?
- Request a grievance if there is dissatisfaction due to a claim being rejected or payment denied because of a precluded provider?
- Place an authorization with the claims processor that allows the drug to pay under a provider not under the preclusion list, but reject for a provider on the preclusion list?

What if there is **no claim history**, for example, because member is a new patient to the precluded provider, post the release of the preclusion date?

30 Days
Plans to review list & notify affected members by mail.

60 Days
Period before Plan rejects Part D claim or denies Part C payment.

Sample Preclusion List Timeline

Starting in **September of 2019**, CMS publishes the Preclusion List by the 25th of each month or the last Monday of the month, whichever is earlier, for the following month.

Action	Date
Preclusion List is posted	11/25/19
Exclusion Date	12/1/19
Plan sends notifications to impacted beneficiaries	12/15/19
Plan begins denying payment/rejecting claims based on the 11/25/19 Preclusion List with dates-of-service (DOS) of 2/29/20 and later	2/29/20

Does this list remove my obligations to check the OIG-LEIE?

No.

The Preclusion List does not replace regulatory requirements related to provider selection, credentialing, and oversight under the regulations at §§ 422.204 (MA organizations), 417.416 (1876 Cost Plans) and 460.64 through 460.71 (PACE organizations).

Use of the Preclusion List does not eliminate or address the responsibility for Medicare plans MA and Part D plans to validate that providers are not included on the Office of Inspector General (OIG) exclusion file.

The Preclusion List and exclusion file overlap in the sense that excluded providers will be on the preclusion list, but precluded providers who are not excluded will not be on the exclusion file. Therefore, if a plan finds a provider on the OIG exclusion file, the plan is not required to check the Preclusion List.

Plans should follow their existing processes for OIG excluded providers and entities, which are based on the exclusion effective date.

The OIG list should take precedence over the preclusion list; consequently, no OIG-excluded provider shall receive payment or the 60-day period addressed in this rule. Once a provider is no longer excluded and a plan must review the preclusion list, there will be instances (based on Medicare reenrollment bars) where a provider is precluded after their reinstatement from an exclusion.

This means, in effect, that if a provider or prescriber is on both the OIG exclusion list and the preclusion list, the MA organization or Part D plan sponsor need not (with respect to that prescriber of provider) carry out the requirements (for example, provide advance written notice to the beneficiary; delay payment denials).

Operational Considerations

- **Who** is able to access the Preclusion List?

- **How** many users are able to access the Preclusion List per Healthcare Plan?

- Will the 30 day period to intake the Preclusion List and distribute the beneficiary notices **apply to each monthly file**?

- **How** are providers removed from the Preclusion List?

- Will there be a circumstance when a provider is **retroactively reinstated**?

- How will provider groups be displayed on the list and **should claims edit** at the TIN or NPI level?

Pharmacies & Part B Drugs

- Are MA/Part D plans required to reject claims from pharmacies on the Preclusion List?

- How about claims for Part B drugs that were prescribed by precluded providers?

- Should pharmacies be removed from networks? Or should claims deny?

- For organizational providers on the Preclusion List, what data elements should plans use when terminating contracts or adjudicating claims?

- Should claims also be rejected or denied for individual providers who are linked to a precluded organizational provider?

Reviewing the 2020 Final Rule Changes Effective 1/1/20 (CMS 4185-F)

- Notification Timeframe

- Provider Notice

- Claim Rejection/Payment Denial Date

- Part D plan guidance for claim rejection

- MA plan guidance for precluded pharmacies

- MA plan guidance for Part B drugs prescribed by precluded providers

- MA plan provider agreements

- Exceptional circumstances

Understanding the Exclusion.

The good, the bad, and the messy.

A national problem

National healthcare fraud, waste, and abuse is a nationwide problem.

Estimates show that anywhere from 3 to 10 percent of the nation's healthcare spending can be attributed to healthcare fraud. Some of the most common examples of healthcare fraud include:

Phantom billing for unnecessary tests or procedures that were never performed.

Upcoding or billing for more expensive supplies or procedures then were actually ordered or performed.

Excessive billing for more than 24 hours of services in 1 day.

Fake billing companies, such as phony pharmacies, that disappear after collecting reimbursement.

Where do exclusions start?
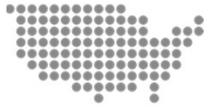
At the State
Level (MFCU)

With a
Licensure Issue

With a Healthcare
Related Misdemeanor
Action

With a Healthcare
Related Felony Action

Defaulting on a
Student Loan

Monitoring Sources
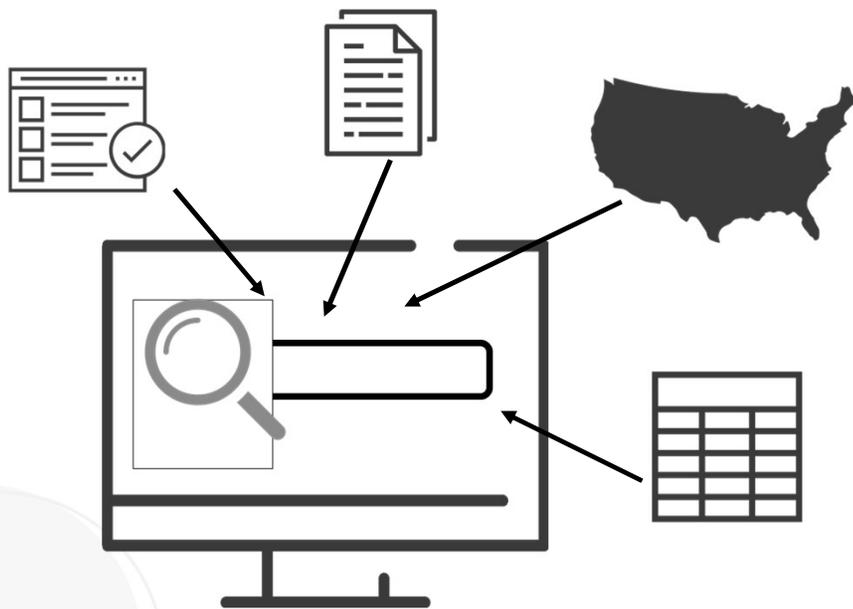
- OIG LEIE
- SAM.gov (Formerly known as EPLS and GSA)
- 43 State Medicaid Exclusion lists
- + the others… (Medicare opt-out, Preclusion list, OFAC, SSA DMF)

There are 45+ lists that you need to be monitoring.

The State of the Exclusion

72,659
OIG Exclusions

+

70,409
SAM Healthcare

+

71,472
State Exclusions

=

214,540 total unique healthcare exclusions

43% of all OIG Exclusions are related to **License Revocation**

States are **required** to report Exclusions to OIG in **30 days.**

The actual average time is **173 days.**

50%+ of SAM exclusions come from HHS.

50%
Of **all** state exclusions **never** show up on the OIG LEIE List

Case Studies

1. Defaulting on a Student Loan

Provider is on the FL Medicaid Exclusion List for non-payment of student loans. What do you do?

If the provider has repaid their defaulted loan, they can contact the excluding state entity, provide proof of repayment and any additional information requested. Typically this will result in the provider being removed from the exclusion.
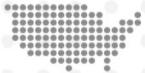
2. At the Federal Level - Federal OIG

Female provider was single when they first graduated and since then they were married. Why is it important to check the previous names?

If you would only check their current name against the exclusions, you could miss exclusions against their maiden name. Exclusions do not transfer with name changes.

The difference is in the data.

Health Plan	Primary Source	Smarter Monitoring
First Name: Meredith	**Exclusion Source:** Maryland State Medicaid Exclusion List	**Exclusion Source:** Maryland State Medicaid Exclusion List
Last Name: Grey	**First Name:** Meredith	**First Name:** Meredith
Location Address: 1760 N Senate Ave, Orlando, FL 33424	**Last Name:** Grey	**Last Name:** Grey
Billing Address: 7050 W Cypress Park Road, Jacksonville, FL 33432	**Address:** 902 McHenry Rd Ste. E, Annapolis, MD 21157	**Address:** 902 McHenry Rd Ste. E, Annapolis, MD 21157
DOB: 05/22/1955	**Exclusion Date:** 10/24/2015	**Exclusion Date:** 10/24/2015
NPI: 1861561547		**NPI:** 1861561547
SSN: n/a		

Note: Actual data and results have been de-identified for presentation purposes.

Insights and the Gaps.

Understanding Preclusions v. Exclusions.

Insights from the initial Preclusion List

The Initial Release

1,336 Records - January 2019

618 Businesses

718 Individuals

All individuals have first & last name, only **519** have middle name or initial

Data Records Contained:

- Business Name
- General
- Specialty
- NPI
- EIN
- Address
- Preclusion Date
- Claim Reject Date

Data Records Contained:

- First
- Middle
- Last
- General
- Specialty
- NPI
- DOB
- Address
- Preclusion Date
- Claim Reject Date

Preclusion List by General Category
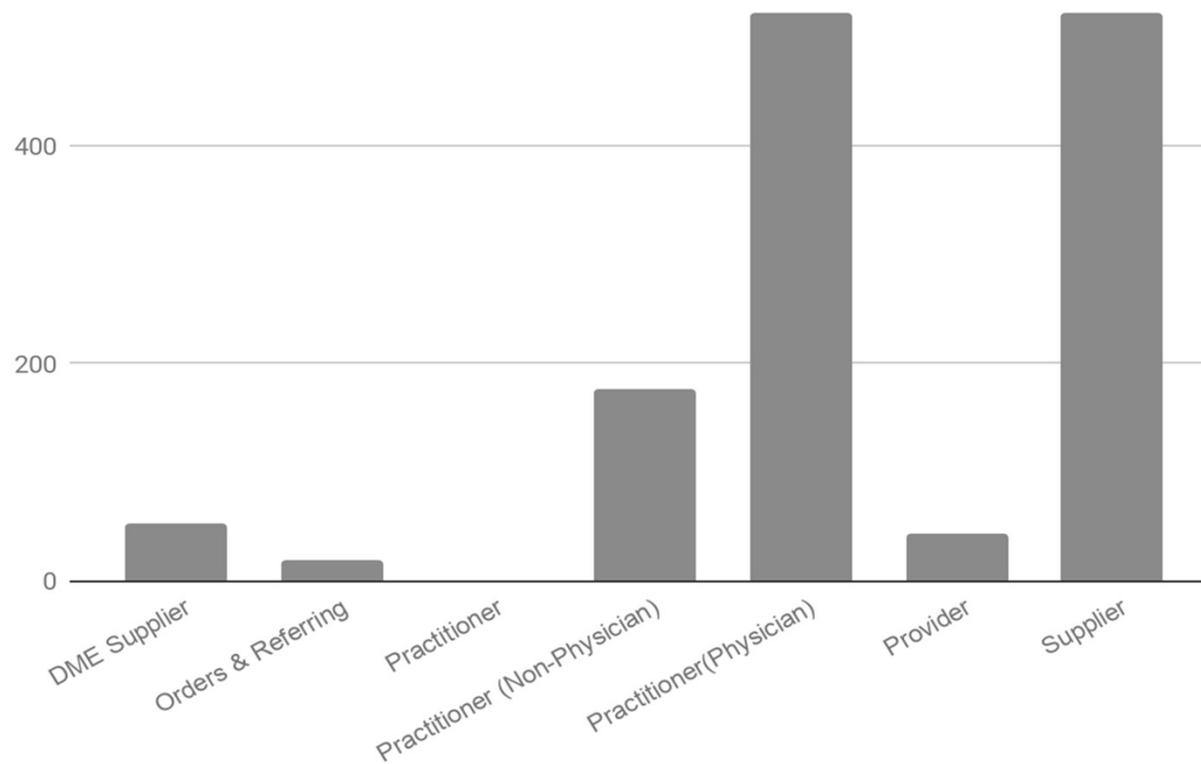
Are precluded individuals/entities also excluded?

48%

of Precluded providers are **also excluded** on any state or federal source

- **27 exclusion sources** (federal and state) represented in Preclusion List
- **77%** of Precluded providers are NOT on the OIG LEIE

In addition to exclusions:
- **7 NPIs** are **inactive**
- **1 NPI** is on the **Medicare Opt Out List**

Preclusion List by Specialty
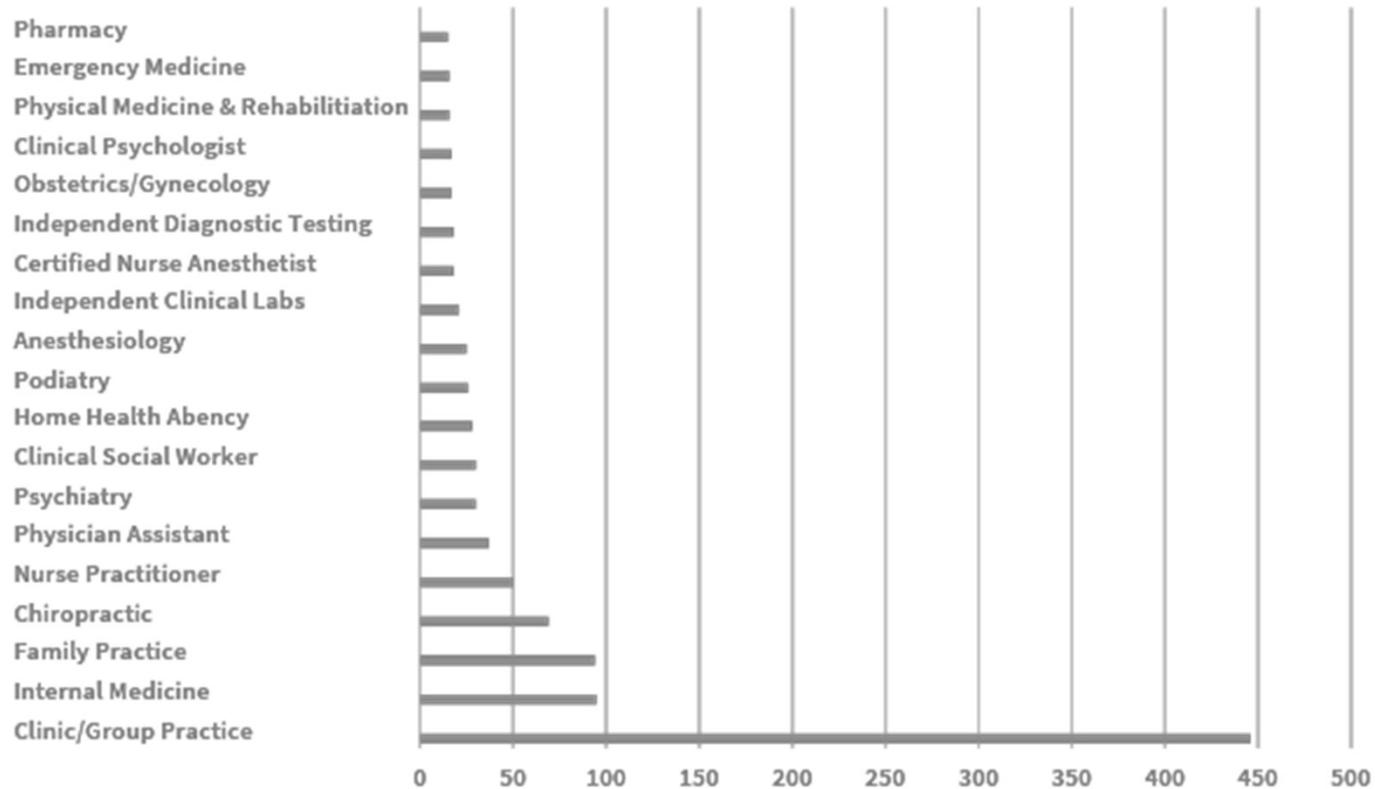
Insights from
12 months of releases.

Total Preclusions v. Exclusions

Exclusions: 642, 649, 649, 692, 717, 761, 774, 785, 796, 813, 826, 838

Total NPIs: 1,336, 1,336, 1,336, 1,418, 1,445, 1,546, 1,580, 1,615, 1,636, 1,693, 1,725, 1,760

Months: January, March, May, July, September, November

○ Exclusions   ▢ Total NPIs

Preclusions v. Exclusions Added

Bar chart comparing NPIs Added and Exclusions Added by month.

| Month	NPIs Added	Exclusions Added
February	0	7
(March)	0	0
April	82	43
(May)	27	25
June	101	44
(July)	34	13
August	35	11
(September)	21	11
October	57	17
(November)	32	13
December	35	12

Legend: NPIs Added, Exclusions Added
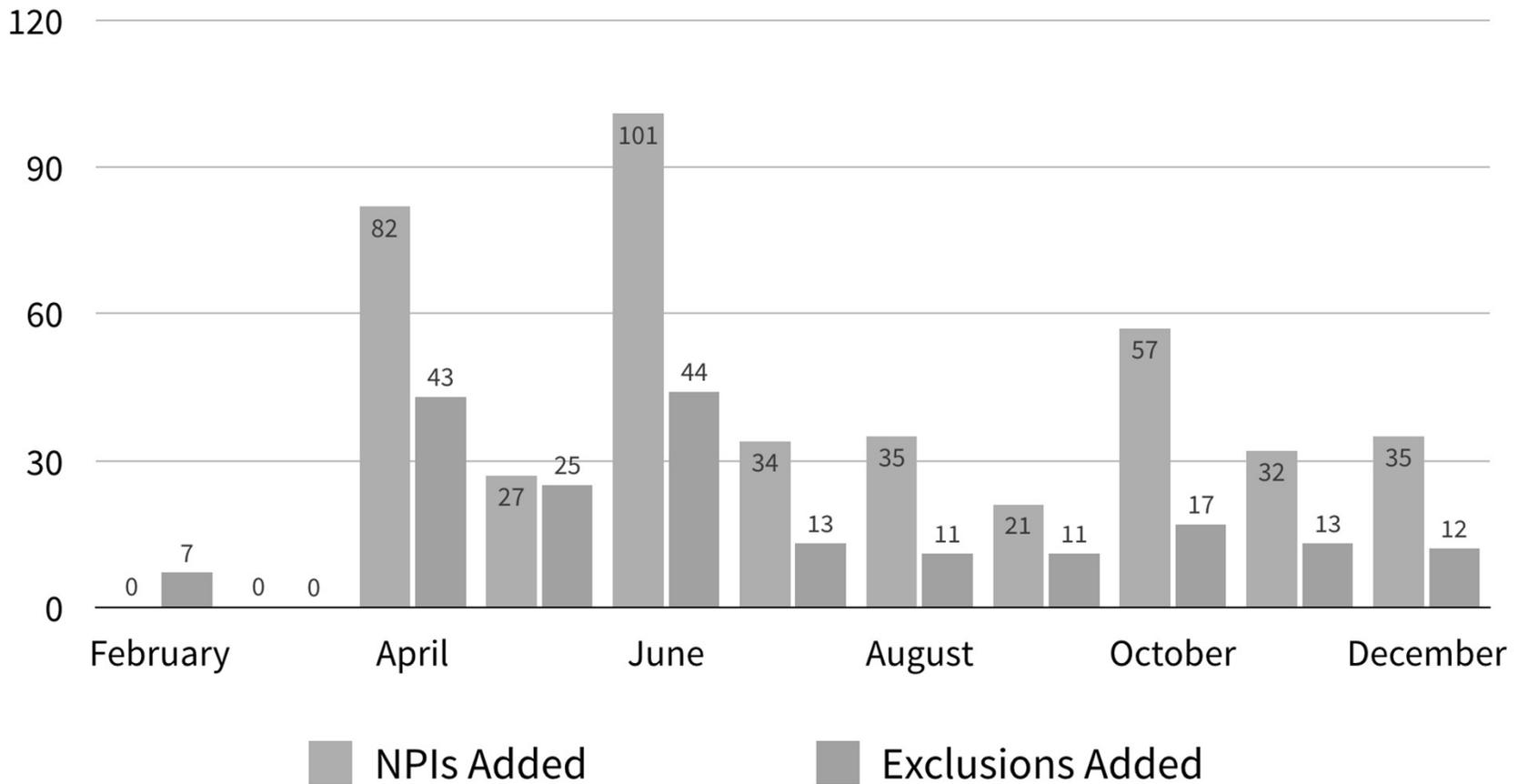
Insights & Analysis

1. In December, **1,760 NPIs were listed on the Preclusion List.** 838 of those were excluded, listed on the OIG LEIE, SAM/GSA, or any of the 43 State Medicaid exclusion lists.
2. On average, **48% of precluded NPIs are also excluded** at a federal or state level.
3. In 2019, **424 providers** were added to the Preclusion List. 196 of those were also excluded.
4. On average, **38 providers** are added to the Preclusion List every month. **18** of those are also excluded.
5. Only **2 precluded providers** are also on the Medicare Opt Out list. **12** NPIs on the Preclusion List are now inactive.
6. **100% of Preclusion List** records contain an NPI Number.

Best Practices in 2020

Holistic provider monitoring is the key to ensuring compliance.

The Provider Lifecycle

Enrollment

Credentialing & Recredentialing

Contracting

Provider Network Participation

Claims Submission and Payment
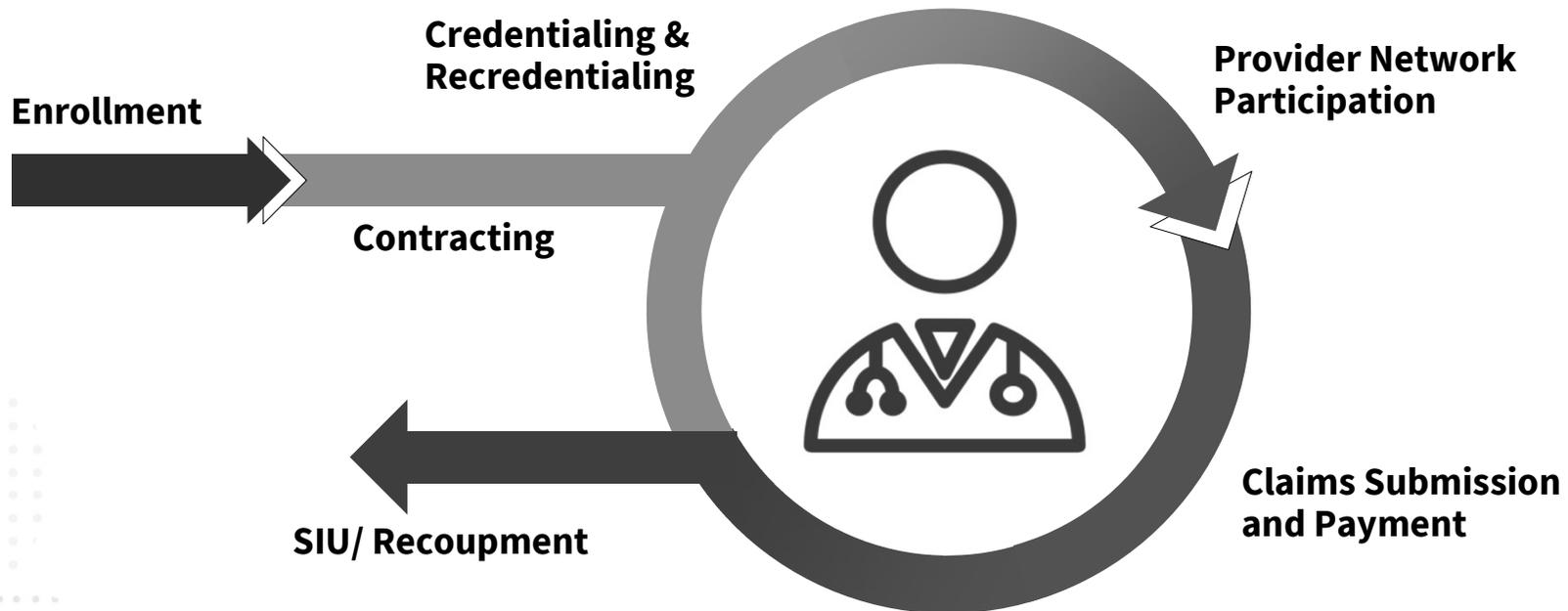
SIU/ Recoupment

Provider Enrollment Screening

Provider screening at enrollment reduces recoupment later.


What *should* this look like?

- Automated
- Integrated into your enrollment process
- Include all appropriate sources:
  - All exclusions sources (LEIE, SAM.gov, 43 state lists)
  - SSA-DMF
  - Medicare Opt-Out
  - CMS ordering and referring
  - FDA/DEA
  - CMS Preclusion List

Evaluating Your Current Process:

1. Are you doing exclusion monitoring **in-house** or **working with a vendor**?
   a. Are you manually verifying potential exclusions?

2. How **often** do you screen your provider network for exclusions?

3. How **accurate** is your provider network data?
   a. Which identifying data are you collecting about your providers?

4. How are exclusions **communicated across teams**? How **quickly** does this occur?

5. Do **multiple teams have access** to exclusion monitoring reports? Are there regular **cross-functional meetings** about exclusion insights?

Key Takeaways

A few recommendations to enhance your operational compliance.
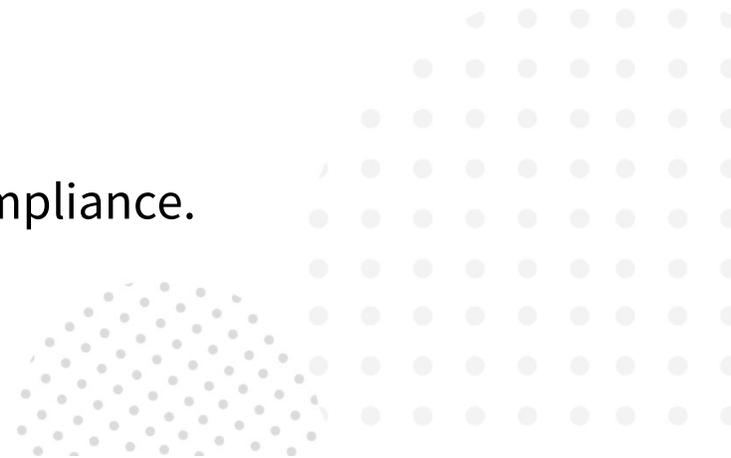
Key Takeaways

1. Establish and ensure **strong monitoring practices.**

2. Evaluate your **monitoring process** for gaps.

3. Connect **monitoring results** with business practices to catch issues quickly.

4. Understand and **consider reporting and documentation requirements.**

Questions?

Exclusions vs. Preclusions

Insights, analytics, and monitoring best practices after one year of releases.