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# Medicare's New 'Preclusion List'

**In his Health Law column, Francis J. Serbaroli explains the Medicare program's new Preclusion List, which identifies health care providers disqualified from providing items or services to Medicare Advantage Plan members or prescription drugs to Medicare Part D beneficiaries. He notes that as of April 1, 2019 no Medicare payments may be made to any providers who are on the Preclusion List, and that Medicare Advantage Plans and Part D drug providers must have notified covered beneficiaries and be ready to begin denying claims.**

**By Francis J. Serbaroli | March 25, 2019 | New York Law Journal**

By way of background, let's start with a short Medicare primer. The federal Medicare program is a government health insurance program that pays for certain health care services for individuals who are 65 or over and have paid into Social Security and Medicare through payroll taxes for the required periods; certain younger people with disabilities; and individuals with End Stage Renal Disease. The Medicare program consists of four Parts. Part A covers inpatient stays in a hospital, nursing facility or hospice, and also covers some home health care. Part B covers physician services, outpatient care, medical supplies and

equipment, and preventive services. Part C is essentially Medicare Part A and Part B combined into managed care coverage offered through private insurers—commonly known as Medicare Advantage Plans—that Medicare beneficiaries can opt into. Part D provides prescription drug coverage through insurance companies, pharmacy benefit managers, and other private entities approved by the Centers for Medicare and Medicaid Services (CMS), which is part of the U.S. Department of Health & Human Services (HHS).

Medicare Part A and Part B are referred to as Traditional Medicare, and services are billed primarily on a "fee-for-service" basis. For decades, the Medicare program has required providers who wished to provide medical care, items, or services to Medicare beneficiaries under Part A or Part B to formally "enroll" in the program and obtain a Medicare provider number. For example, when a physician provides Part B medical services in the office to a Medicare patient, the physician must be an enrolled provider with Medicare, and the physician's office would submit a bill for services rendered to a Medicare intermediary for a Part B payment. When Part C, the Medicare Advantage Plans, and the Part D Medicare prescription benefit programs were established, the enrollment requirement continued for any provider rendering services or prescribing drugs under these benefit programs.

A provider's enrollment in Medicare can be revoked. For example, if an enrolled provider was determined to have provided consistently poor care, or unnecessary care, or had defrauded the Medicare programs by billing for services not rendered, or had violated any of the fraud and abuse laws, the HHS Office of Inspector General (OIG) could move to "exclude" the enrolled provider, i.e., bar the provider from receiving payments from Medicare for prescribing or providing any services or items for Medicare patients. Exclusion is mandatory if a provider has been convicted of certain crimes. 42 USC §1320a-7(a). Other exclusions are "permissive", i.e., in the discretion of the OIG, depending upon the underlying circumstances. 42 USC §1320a-7(b). A list of all excluded providers is maintained on the OIG's website and regularly updated.

This Medicare exclusion penalty is often referred to as the professional equivalent of a death sentence since it not only prohibits excluded providers from billing Medicare for services but also prevents an excluded individual from being employed by an organization, such as a hospital, that receives revenues from Medicare. An organization receiving Medicare revenues that employs or deals with an excluded provider is itself subject to a variety of fines and penalties, up to and including its own exclusion from Medicare.

**Preclusion List**

On April 16, 2018, CMS rescinded the enrollment requirement for:

• Providers who prescribe drugs to patients enrolled in Medicare Part D; and

• Network providers and suppliers that furnish health care items or services to a Medicare beneficiary who receives his or her Medicare benefit through a Medicare Advantage (MA) organization.

83 Fed. Reg. No. 73, 16641.

CMS stated that its reasons for eliminating the enrollment requirement included reducing the burden on prescribers and providers to Medicare Advantage Plans and Part D plans without compromising Medicare's program integrity efforts; and preventing payments for drugs under Part D by demonstrably problematic prescribers. It also estimated that eliminating the enrollment requirement would save CMS $34.4 million just in 2019.

The enrollment requirement was replaced by what CMS refers to as its "Preclusion List". This new List identifies prescribers, individuals and entities that fall within the following categories:

(1) 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; and

(2) Have engaged in behavior for which CMS could have revoked the prescriber, 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. Such conduct includes, but are [sic] not limited to, felony convictions and [OIG] exclusions.

Preclusion List FAQs, CMS.gov.

The first Preclusion List was issued in January 2019, and the providers on this List were precluded effective Jan. 1, 2019. However, CMS has informed Medicare Advantage Plans and Part D plan sponsors that they will not be required to begin denying claims by providers on the Preclusion List until April 1, 2019.

By April 1, 2019, members of a Part C Medicare Advantage Plan are to be notified by their Plan if they have received services within the past 12 months from a provider that CMS is adding to the Preclusion List. The member will then have 60 days to find a non-precluded provider. At the end of the 60-day period, Plans are to deny payments for claims for medical services or items from the precluded provider. Similarly, Part D beneficiaries will be notified if they have been prescribed or received prescription drugs from a provider being added to the Preclusion List. The beneficiary will have 60 days to select another provider who is not on the Preclusion List. If the beneficiary decides to continue receiving prescriptions from a precluded provider, CMS states that the prescription will be rejected or denied at the pharmacy. The beneficiary can still pay out-of-pocket and receive the prescribed drug, but the Medicare Part D plan will neither pay for the drug nor reimburse the beneficiary.

Unlike the OIG's very public list of providers excluded from Medicare and other federal health benefit programs, CMS's Preclusion List will not be public, but it is being made available to Medicare Advantage Plans and Part D plan sponsors. CMS will be updating its Preclusion List on a monthly basis.

**Appeal of Preclusion**

CMS will notify providers that are to be added to the Preclusion List via their email address on file. In addition, CMS's regional Medicare Administrative Contractor (MAC) will mail a written notice to the provider explaining the reason(s) for the preclusion, the date that the preclusion goes into effect, and how to go about appealing the preclusion. CMS states that providers who are notified that they are being placed on the Preclusion List will have appeal rights in accordance with the provisions of 42 CFR Part 498. Providers won't be added to the Preclusion List until they have exhausted their first level of appeal. If this appeal is denied or the provider fails to submit an appeal, the provider will be added to the Preclusion List.

CMS's Preclusion List will be different from the OIG's exclusion list, although there will undoubtedly be providers who make both lists. All those on the OIG's list of excluded providers are completely debarred from the Medicare program and presumably would not have to be added to the Preclusion List.

**Duration of Preclusion**

Providers that have previously been denied re-enrollment in Medicare will be included on the Preclusion List for the duration of their re-enrollment bar if they are currently revoked or would have been revoked had they enrolled in the Medicare program. CMS's re-enrollment bar is a minimum of one year but not more than three years depending upon the severity of the reason(s) for the revocation. CMS indicates that

there will be no retroactive application of preclusion once a provider is placed on the Preclusion List. However, affected providers will not automatically drop off the Preclusion List; the List will be updated by CMS to indicate the date when the affected provider is no longer precluded.

It is incumbent upon all Medicare Advantage Plans and Part D plan sponsors to review the Preclusion List that has been in effect since Jan. 1, 2019 and to notify members who have obtained items, services, or prescription drugs from precluded providers that they must transfer to a non-precluded provider. Plans and Part D plan sponsors must be prepared to start denying claims from providers on the Preclusion List by April 1, 2019. This means updating their IT and claims processes, as well as their compliance policies and procedures. Since this is a significant new requirement that will likely require some fine-tuning, it is important to be aware of continuing guidance on the Preclusion List from CMS.

It is also important to note that, since the Preclusion List is not public and is intended only for Part C Medicare Advantage Plans and Part D Plan sponsors, there is no obligation on the part of other providers to be aware of or act on the Preclusion List the way that they have to with regard to the OIG's Excluded Provider list.



**About the Author:**

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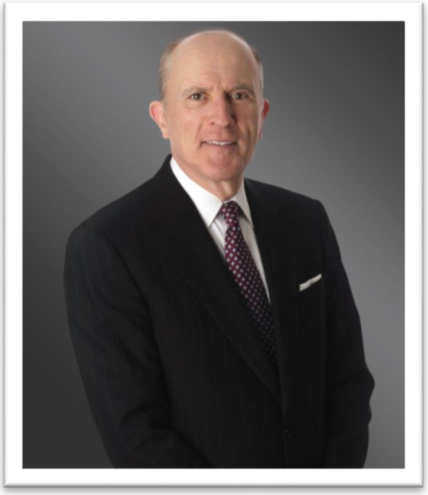

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