Department: Compliance	Effective Date: January 30, 2019
Unit: Special Investigations Unit	Most Recent Revision Date: October 21, 2020
Procedure Title: Preclusion List Screening	Applies to: ☑ MCS Advantage, Inc. ☐ MCS General Insurance Agency ☐ MCS Life Insurance Company
Approved by: Corporate Compliance Committee	

PURPOSE

MCS Advantage, Inc. reviews the Preclusion List issued by CMS prior to hiring or contracting any new provider and/or facility and monthly thereafter to ensure that none of these persons or entities are included in the Preclusion List.

MCS terminates immediately contractual relationship with a provider and/or facility that is included in the Preclusion List. Beginning on April 1, 2019, MCS and its FDRs will not make payment for a health care item or service furnished by an individual or entity included in the Preclusion List, including or emergency or urgent care circumstances.

The Special Investigations Unit is responsible of performing an ongoing monitoring of MCS applicable operational areas screening against the Preclusion List.

PROCEDURES

A. Access to the Preclusion List:

1. The Special Investigations Unit Manager and/or designated person is responsible for accessing the Preclusion List as issued by CMS. Updates to the Preclusion List will be published by CMS by the 25th of each month or the last Monday of the month, whichever is earlier.

2. Immediately upon CMS make accessible the list in the secure website and not later than three (3) days after the list was updated by CMS, the Special Investigations Manager deposits the Preclusion on the following designated share folder:

\\mcs.local\compliance\CMS Preclusion List

B. Screening Performed by MCS:

1. MCS's Business Intelligence Unit (BIU) is responsible of screening the Preclusion List against the medical claims, including claims processed by First Tier Entities as applicable, and pharmacy claims. The purpose of this screening is to identify enrollees who have received care (based on claims utilization) in the last 12 months from a provider or a prescription from any provider included on the preclusion list. This process should be completed not later than twenty (20) days after the date when the list was updated by CMS. The report prepared by the BIU is sent to the Physician Network Unit and deposited in the following share folder: (\\mcs.local\compliance\CMS Preclusion List).

2. The Physician Network Unit is responsible of screening the Preclusion List against the MCS's contracted providers and facilities to identify any contracted provider and/or facility that is included in the Preclusion List when the list is posted and prior to contract any provider and/or facility. Also, the Physician Network Department is responsible of the following processes:

    a. Notifies enrollees who have received care in the last 12 months from a provider or a prescription from a provider included in the preclusion list (including services related to contracted or non-contracted providers), no later than thirty days (30) from the posting of the list. This provides the enrollee at least a sixty (60) days advance notice before MCS denies payment/rejects claims associated with a precluded provider.

    b. Removes any contracted provider, who is included in the Preclusion List, from MCS's network as soon as possible according to the applicable contracts' provisions.

        i. Notify the provider that he/she cannot longer treat MCS's enrollees and provide a list of all MCS's enrollees who have received services over the past 12 months as soon as possible. This process should be implemented no later than 30 days after the date the provider has become precluded.

    c. Performs a verification of the Preclusion List prior to contract any provider and/or facility to ensure that MCS does not engage in any contract with a provider included in the preclusion list for providing health care services to MCS's enrollees.

    d. Notifies the MCS's Configuration Unit of any provider that requiring a hold code configuration in the claims processing system to identify providers included in the Preclusion List. The applicable hold codes are:

        i. 9K - Provider on Preclusion List

        ii. 9J – Provider on HHS-OIG & Preclusion List

    e. The effective date of the hold code shall be according to the effective date notified by CMS in the Preclusion List file as updated.

3. The business operational owners (e.g. Pharmacy Department, Clinical Operational Unit and Physician Network Department) in charge of the supervision of delegated entities who process claims for services related to MCS's enrollees and/or contract providers (e.g. PBM, entities who manage mental, dental, vision and/or therapy services) are responsible of distributing the list to the applicable entities and assuring that an attestation from each entity is received indicating that applicable actions were implemented to ensure that not payment will be made for a health care item or service furnished by an individual or entity included in the Preclusion List, including emergency or urgent care circumstances. These attestations should be received not later than thirty days from the posting of the list by CMS.

4. The Claims Department is responsible of ensuring that no submitted claims are paid and/or reimbursed to any billed service related to precluded provider after the effective date of the hold code included by MCS, including emergency and urgency circumstances.

5. The Configuration Unit is responsible of screening against the current Preclusion List any MCS's non-contracted provider prior to create a record in the MCS's core system.

C. Special Investigations Unit (SIU) Oversight:

1. For the purpose of documenting the applicable actions performed by the operational areas, the SIU:
    a. Creates and assigns a task through the Compliance 360 application to the designated personnel of the following departments: Business Intelligence, Clinical Operations, Physician Network and Pharmacy.
    b. The due date of this task shall be according to the process as detailed in this Procedure.
    c. The process should be completed not later than thirty (30) days upon the list published by CMS.
    d. The SIU evaluates the monthly verifications conducted by the applicable MCS Departments to validate that applicable actions were implemented as requested by MCS and documented accordingly through Compliance 360. Each assigned task is approved as completed or referred with applicable recommendations to the areas as deemed necessary.

2. One day before the expected completion date of the tasks assigned to the areas, the SIU designed staff sends a reminder to the areas with outstanding task to be completed and applies an escalation notification process via e-mail including the management of the applicable area.

DEFINITIONS

1. Centers for Medicare and Medicaid Services (CMS): The Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program.

2. FDRs: First Tiers, Downstream and Related Entities:

- First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

- Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

- Related Entity: Any entity that is related to a MAO or Part D sponsor by common ownership or control and (1) Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;(2) Furnishes services to Medicare enrollees under an oral or written agreement; or (3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.

3. Preclusion List – The Preclusion List will consist of providers (individuals and entities) that fall within either of the following categories:

    - Are currently revoked for Medicare, are under and active reenrollment bar, and CMS determines 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 extend 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.

REFERENCES

- 42 CFR 422.222
- CMS-4182 F published on April 16, 2018
- HPMS Memo issued by CMS on November 2, 2018, Preclusion List Requirements
- HPMS Memo issued by CMS on December 14, 2018, Preclusion List Frequently Asked Questions (FAQs)

ATTACHMENT(S)

N/A

RELATED MCS POLICIES & PROCEDURES

- MCS Compliance Program
- MCS-Policy-006 Effective System for Routine Monitoring, Auditing
- MCS-Policy-010 Document Retention and Access to Records by Federal and Commonwealth Regulatory Authorities
- CA-FWA-004 Investigation Management Process of Suspected Fraud, Waste, and Abuse/Integrity Program
- PR-CRED-002 Credentialing Program Scope
- PR-CRED-005 Verification Time Limits
- PR-CRED-006 Eligibility Criteria for Professional Conduct and Competence
- PR-CRED-009 Credentialing Procedures for Practitioners
- PR-CRED-012 Re-credentialing Application
- PR-CRED-014 Terminations and Immediate Terminations
- PR-CRED-027 Medicare and Medicaid Sanction Verification
- PR-CRED-033 Reinstatement of Excluded Providers
- PR-CRED-034 Monitoring for Medicare Opt-Out, Medicare & Medicaid Sanctions, State License Limitations, Grievances & Appeals and Others
- SC-SC-005 Identification and Configuration of Non-Contracted Providers

PROCEDURE REVISIONS:

DATE	CHANGE(S)	REASONS
10/21/2020	Minor changes and clarify that letters to enrollees are sent for services identified for contracted and non-contracted providers.	Annual review

11/06/2019	Clarify when the list is updated by CMS based on the HPMS Memo received in August 2019. Attestation requirement and possible positives validations eliminated; not required as Compliance 360 assignment is created as a task and possible positive validations are evaluated by the providers area and system configuration areas.	Annual review
01/30/2019	Creation of procedure to comply with new regulatory requirement	New regulatory requirement