

CMS UPDATES PRECLUSION LIST REQUIREMENTS FOR MEDICARE ADVANTAGE AND PART D

The Centers for Medicare & Medicaid Services (“CMS”) recently published a **final rule** (“Final Rule”) revising the procedures that CMS uses to administer its Preclusion List. As outlined below, CMS now requires Medicare Advantage, Medicare Part D and other designated plans to deny payment for items or services provided by or prescribed by a provider that appears on the Preclusion List. Hall Render’s article outlining the Preclusion List’s key requirements can be found [here](#). The Final Rule modifies and clarifies CMS’s approach to numerous aspects of Preclusion List operations, including appeal rights for those placed on the Preclusion List (“Listed Providers”) and the timing of their placement on the Preclusion List, along with beneficiary notification and claim denial requirements. The Final Rule’s key provisions are summarized below. While these changes do not impact the overall structure of the Preclusion List, they do affect the rights and obligations of Plans and providers. These modifications should be carefully considered as Plans and providers continue to adapt their practices in response to the Preclusion List.

BACKGROUND

In April 2018, CMS rescinded the requirement for health care providers and suppliers to enroll in Medicare to be paid for items, services or drugs provided to patients covered by a Medicare Advantage plan, Medicare Part D plan, PACE Organization or 1876 cost contract plan (collectively, “Plans”). Rather than requiring enrollment, CMS created the Preclusion List, which is a list of prescribers, individuals and entities that have either been revoked from Medicare, have engaged in behavior that would have led to revocation or have been convicted of a felony CMS considers detrimental to federal health care programs within the last 10 years. As of April 1, 2019, Plans must deny payment for any claims for items or services provided by Listed Providers.

SUMMARY OF CHANGES

The Final Rule makes numerous revisions to CMS’s Preclusion List procedures, as listed below. Most of these changes are effective on January 1, 2020, but the first change, regarding Listed Provider appeal rights, is effective on June 15, 2019.

- **Listed Provider Appeal Rights.** Listed Providers are added to the Preclusion List only upon exhaustion of their first level of appeal. Previously, when CMS revoked a provider’s enrollment, the provider could appeal first the revocation then the resulting placement on the Preclusion List. CMS determined that this approach would lead to a significant gap in time between its initial decision to revoke the provider’s enrollment and his or her eventual placement on the Preclusion List. CMS consolidated this process by requiring such a provider to appeal both the revocation and the placement on the Preclusion List at the same time.
- **Claim Denials and Beneficiary Notification.** Under CMS’s existing rules, Plans would be required to deny claims for services or supplies written by Listed Providers as of the day the Listed Provider was added to the Preclusion List. In the previous rule, CMS created a grace period of up to 90 days that applied only to the initial publication of the Preclusion List in January 2019. The Final Rule applies this grace period to all Preclusion List updates that occur on or after January 1, 2020. After that date, within 30 days of the publication of an update to the Preclusion List, CMS requires Plans to make reasonable efforts to provide written notice to any beneficiary who has received any item or service from a newly added Listed Provider. Plans may not deny payment for a service or item furnished by such a Listed Provider until 60 days after the date of this notice. Claims will be denied or rejected only after this combined time frame which may be anywhere from 61-90 days depending on the date of notice to the beneficiary. Furthermore, Plans are required to agree that beneficiaries will not incur any financial liability for services or items furnished to them by a provider on the Preclusion List.
- **Felony Convictions.** In the Final Rule, CMS modified its regulations to allow for a provider to be placed on the Preclusion List if the provider is convicted of a felony that CMS determines is detrimental to the best interests of the Medicare Program. In determining whether a provider will be placed on the Preclusion List due to a felony conviction, CMS will consider the severity of the offense, when the offense occurred and any other information relevant to its determination. The new regulations allow CMS to look back 10 years in a provider’s conviction history, and CMS will include a provider on the Preclusion List due to a felony conviction for a period of 10 years beginning on the date of the felony conviction. This may mean that some providers are included on the Preclusion List for less than 10

years even if CMS imposes the full 10-year period. CMS notes in commentary that it will be addressing operational issues in guidance when necessary and appropriate.

- *Clarification of Prior Statements.* CMS made several revisions to its regulations that it had discussed, but not codified, in previous rules. These include codifying the date on which providers will be added to the Preclusion List and clarifying that beneficiaries are not entitled to appeal when a claim is denied because their provider was on the Preclusion List. CMS also made other minor regulatory changes to take account of variances in state laws.

PRACTICAL TAKEAWAYS

In light of the April 1, 2019 effective date for claim rejection, Plans should already be reviewing the Preclusion List and have procedures in place to identify and reject any claims submitted by providers that are on the list. Plans should also have a process in place to provide written notice to beneficiaries, noting that while they must provide notice within 30 days, the sooner the notice is provided, the sooner they may deny claims.

Providers should continue to monitor communications from CMS and Plans regarding the Preclusion List, given that only Plans – and not providers – will have direct access to the Preclusion List. Providers who have been convicted of a felony within the last 10 years must consider whether the nature of the offence is such that CMS may place them on the Preclusion List. Providers who receive notice of both exclusion and preclusion should be aware that they are required to file a joint appeal and plan accordingly.

For additional information, CMS's Preclusion List webpage is available [here](#). Hall Render will continue to monitor Preclusion List developments as this process moves forward. If you have any questions about how your organization can implement these new requirements, please contact:

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