SummaCare

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Policy Number: CSCL0007
Manual Name: SMO Policy Manual
Policy Name: Exclusion screening for providers
Approved By: Stephen Adamson
Last Revised: 06/27/2019

SMSO Policy Manual
EXCLUSION SCREENING FOR PROVIDERS

Executive Sponsor:	Stephen Adamson, Chief Operations Officer
Issuing Department:	Claims
Gate Keeper:	Melissa Rusk, Director Claims

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Health Management Company
- ☐ Apex
- ☐ Summa Insurance Company

Line of Business:

- ☐ Commercial Groups
- ☐ Medicare Supplemental
- ☐ Off-Exchange
- ☒ Medicare
- ☐ On-Exchange
- ☐ Self-Funded

1.0 Purpose:

1.1 To ensure that no government health care program payment is rendered to ineligible providers or entities. This policy/procedure only addresses Part C and health care providers. Responsibility for exclusion screening in Part D is delegated to MedImpact. Sanction screening for First Tier Entities is addressed in a separate policy.

2.0 Policy:

2.1 Medicare payments may not be made for items or services furnished or prescribed by an excluded provider or entity. The Plan will not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the DHHS OIG or GSA, and will utilize the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) to prevent contracting with or paying claims from excluded providers.

3.0 Procedure:

3.1 Initial Sanction Screening – Providers

3.1.1 The Credentialing Department conducts initial exclusion screening checks prior to contracting with a health care provider or entity to provide medical services to a Medicare Advantage member.

3.2 Monthly Sanction Screening

3.2.1 For Part C services, SummaCare utilizes data files created by a vendor, Health Market Science (HMS).

3.2.1.1 The vendor provides monthly data files based on federal and state exclusion lists, which are reviewed against the plan's provider data records. Any matched records automatically generate a report (CM261 Sanction Report) that provides details related to the excluded individual or entity.

3.2.1.2 IS-OPS posts the monthly CM261 sanction reports to the SummaCare Sharepoint database at S:\Shared_IS Config\HMS_Sanction_Reports.

3.2.1.3 The CM261 reports are reviewed to ensure no inappropriate payments are made to healthcare providers and entities that are excluded from participation in federal programs.

3.2.1.3.1 Credentialing reviews the report for positive findings. If positive findings are found for participating providers, action is taken as documented in the Credentialing policy "Ongoing Monitoring of Physicians/Practioners" which includes the initiation of the termination process and communication to Configuration.

3.2.1.4 Configuration reviews the report for positive findings. If positive findings are found for non-contracted providers who are already in the claim system, a non-payment flag is set for the excluded provider(s).

3.2.1.5 When a claim is submitted for a provider who is not in the claims system, the most recent sanction list is reviewed to determine if the provider is excluded. If so, the provider is loaded as such.

3.3 Reporting:

3.3.1 Configuration generates monthly sanction activity reports for review by Compliance. The report includes:

3.3.1.1 Provider identifiers such as name, NPI and effective date of exclusion

3.3.1.2 Exclusion reason, effective and terminate date

3.3.1.3 Action taken by Configuration

3.4 Melissa Rusk, Director, Claims & BPO Operations has the authority and responsibility for the activities in this policy or procedure.

3.5 The Issuing Dept. is responsible for monitoring and enforcing compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 Standards: 42 C.F.R. §422.503 (b)(4)(vi)(F); 422.752 (a)(8); 423.504 (b)(4)(vi)(F); 423.752 (a)(6); 1001.1901

4.1.2 Medicare Managed Care Manual (Chpt 21)

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Other policies that work in conjunction with this policy:

4.3.1 Exclusion Screening for First Tier Entities

4.3.2 Exclusion Screening

4.3.3 Required Criteria for Participation Policy (Credentialing)

4.3.4 Ongoing Monitoring of Physicians/Practitioners Policy (Credentialing)

5.0 Definitions:

None

6.0 Key Words or Aliases (Optional):

None

ORIGINAL EFFECTIVE DATE: 10/01/2017
REVIEWED: 2/2014
REVISED: 3/2014, 6/2015 (updated format, clarified procedures), 8/24/2017, 5/29/2019, 6/27/2019 (updated format)