Chapter 13 Section 5

Provider Exclusions, Terminations, And Suspension of Claims Processing

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1.0 SCOPE AND PURPOSE

This section specifies which individuals and entities may, or in some cases must, be excluded from the TRICARE program. It outlines the authority given to the Department of Health and Human Services/Office of Inspector General (DHHS/OIG) to impose exclusions from all Federal health care programs, including TRICARE. This section also outlines the Defense Health Agency (DHA) authority for exclusions and terminations. In addition, this section states the effect of exclusion, factors considered in determining the length of exclusion, and provisions governing notices, determinations, and appeals. This section also outlines procedures and protocol for suspension of claims processing.

2.0 DHA AUTHORITY FOR SUSPENSION OF CLAIMS PROCESSING

2.1 DHA may suspend claims processing based on 32 CFR 199.9 provisions.

2.2 The Director, DHA or designee may suspend claims processing without notifying the provider or beneficiary of the intent to suspend payments. A written notice will advise the beneficiary or provider, within 30 days of the claims suspension, that a temporary suspension has been ordered and a statement of the basis of the decision to suspend payment.

2.3 A suspension of claims processing shall be for a temporary period pending the completion of investigation and any ensuing legal or administrative proceedings, unless sooner terminated by the Director, DHA or designee. See 32 CFR 199.9 for additional guidance.

2.4 DHA Program Integrity Office (PI) is responsible for advising the contractor of any suspension of claims processing. The contractor shall then issue special notifications. (Addendum A, Figure 13.A-6, Figure 13.A-7, and Figure 13.A-8.)

3.0 DHA AUTHORITY FOR EXCLUSIONS AND TERMINATIONS

3.1 DHA may exclude any individual or entity based on 32 CFR 199.9 provisions.

3.2 Effective March 28, 2013, third party billing agents or entities became subject to TRICARE sanction authority.

3.3 The contractor shall provide written notice to DHA PI of any situation involving a TRICARE provider, pharmacy, or entity whose actions warrant exclusion under DHA authority.

3.4 The Director, DHA or designee, has the authority to exclude an authorized TRICARE provider, pharmacy, or entity. The period of exclusion is at the discretion of DHA. (See 32 CFR 199.9.)

3.5 DHA PI is responsible for coordinating and issuing notification of exclusion action. DHA PI will send written notice of the proposed exclusion, and the potential effect thereof. The individual or entity may submit evidence and written argument regarding the proposed exclusion.

3.6 DHA PI has sole authority to issue an Initial Determination of Exclusion. Written notice of this decision will include the basis for the exclusion, the length of the exclusion, as well as the effect of the exclusion. The determination also outlines the earliest date on which DHA PI will consider a request for reinstatement, the requirements for reinstatement, and appeal rights available. DHA PI will notify appropriate agencies, to include contractors, of all DHA exclusion actions taken. DHA PI will be responsible for initiating action based on reversed or vacated decisions. Exclusion of a provider, pharmacy, or entity shall be effective 15 calendar days from the date of the Initial Determination.

3.7 The Director, DHA or designee has sole authority for approval of any request for reinstatement.

4.0 CONTRACTOR ACTIONS UNDER TRICARE EXCLUSION AUTHORITY - 32 CFR 199.9

4.1 When the contractor recommends exclusion to DHA PI of an authorized provider, pharmacy or entity, supporting documentation must be submitted (e.g., provider, pharmacy, or entity poses unreasonable potential for fraud).

4.2 The contractor will be notified immediately of an exclusion action taken by DHA PI and is responsible for:

- Ensuring that no payment is made to an excluded provider, pharmacy, or entity for care provided on or after the date of the DHA action (15 calendar days from the date of the Initial Determination as noted in paragraph 3.6). Neither the provider, pharmacy, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is in effect. The contractor shall notify DHA PI should a provider, pharmacy, or entity attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider, pharmacy or entity of the exclusion action. However, notice of exclusion action taken by DHA shall be given to all Beneficiary Counseling and Assistance Coordinators (BCACs) contractor employees that interface with beneficiaries located within the provider's service area (approximately 100 miles) of the practice address of the excluded provider. The contractor will also notify the Director, TRICARE Regional Office in the geographical area(s) of the provider's practice of action taken. TRICARE Area Offices (TAOs) for the region in which the provider's practice is located shall also be given notice of exclusion action taken.

- Ensuring that an excluded provider, pharmacy, or entity is not included in the network. If cancellation of a network provider, pharmacy, or entity agreement is required, the contractor shall ensure that the network provider, pharmacy, or entity whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing written notice, sent by certified mail, return receipt requested, that the network provider's or network pharmacy's agreement has been cancelled. (Contractor will send a copy to DHA PI).

- Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving an excluded provider pharmacy or entity. The notice may be enclosed with the Explanation of Benefits (EOB, whether the claim is payable or not, or be sent as a separate letter.

- Contractors shall ensure the enforcement of all exclusion action taken, and notify appropriate parties of the application of exclusions. For example, any claim received from an excluded third party billing agent shall be returned to the provider with instructions to resubmit the claim directly or through another third party billing agent. The provider remains entitled to reimbursement for covered services as long as they remain an authorized TRICARE provider.

5.0 DHHS/OIG APPLICATION OF SANCTION AUTHORITY

5.1 DHHS/OIG can exclude individuals or entities from participation in any federal health care program to include the Department of Defense (DoD) Military Health System (MHS). Authority and exclusion categories can be found on the DHHS/OIG web site.

5.2 DHHS/OIG has sole responsibility for issuing a written notice of its intent to exclude a provider, pharmacy, or entity, the basis for the exclusion, the effective date, the period of exclusion, and the potential effect of exclusion.

5.3 DHHS/OIG has sole authority for terminating an exclusion imposed under their authority. DHHS/OIG will handle notifications of approval/denial of a request for reinstatement and are responsible for reversing or vacating decisions.

5.4 DHHS/OIG exclusions and reinstatements are issued on a monthly basis. DHHS/OIG will provide DHA PI with immediate access to this information, which will then be forwarded to each contractor.

5.5 Exclusions taken by DHHS/OIG are binding on Medicare, Medicaid, and all Federal health care programs with the exception of the Federal Employee Health Benefit Program (FEHBP) (42 USC 1320a-7b(f)). No payment will be made for any item or service furnished on or after the effective date of exclusion until an individual or entity is reinstated by DHHS/OIG, and subsequently meets the requirements under 32 CFR 199.6.

6.0 CONTRACTOR ACTIONS UNDER DHHS/OIG EXCLUSION AUTHORITY

6.1 The contractor will be provided the monthly issuance of DHHS/OIG exclusion and reinstatement actions.

6.2 The contractor shall ensure that no payment is made to an excluded provider, network pharmacy, or entity for care provided on or after the date of the DHHS/OIG action. Neither the provider, pharmacy, or entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor shall notify DHA PI should a provider, network pharmacy, or entity attempt to bill the program or if payment has been issued after the effective date of exclusion. It is not be necessary for the contractor to issue a separate letter notifying the provider, network pharmacy, or entity of the exclusion action.

6.3 The contractor shall ensure that an excluded provider, pharmacy, or entity is not included in the network. If cancellation of a network, or if applicable, participating provider agreement is required, the contractor shall ensure that the network provider or network pharmacy whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing written notice, sent by certified mail, return receipt requested, that the network provider's or network pharmacy's agreement has been cancelled. (Contractor shall send a copy to DHA PI.)

7.0 CONTRACTOR APPLICATION OF SANCTION AUTHORITY

Contractors shall ensure the enforcement of all sanction action taken, and notify appropriate parties of the application of sanctions. For example, any claim received from an excluded third party billing agent shall be returned to the provider with instructions to resubmit the claim directly or through another third party billing agent. The provider remains entitled to reimbursement for covered services as long as they remain an authorized TRICARE provider.

8.0 PROVIDER, NETWORK PHARMACY, OR ENTITY TERMINATION OF AUTHORIZED PROVIDER STATUS

8.1 The contractor will terminate the authorized provider status of any provider, network pharmacy, or entity determined not to meet program requirements. The request for reinstatement will be processed under the procedures established for initial requests for authorized provider or network pharmacy status. See Section 6 for further information.

8.2 Other Listings

Other listings of actions affecting provider authorization status (e.g., Federation of State Medical Boards of the United States (U.S.)) will be sent to each contractor. A provider who has licenses to practice in two or more jurisdictions and has one or more licenses suspended or revoked shall be terminated as a TRICARE provider in all jurisdictions.

9.0 CONTRACTOR REQUIREMENTS FOR TERMINATION

When status as an authorized provider, authorized network pharmacy or authorized entity is ended, the contractor shall initiate termination action based on a finding that the provider, pharmacy, or entity does not meet the qualifications to be an authorized provider. Separate termination action by the contractor is not required for a provider, pharmacy, or entity sanctioned under the exclusion authority granted DHHS/OIG.

9.1 The period of termination will be indefinite and will end only after the provider, pharmacy, or entity has successfully met the established qualifications for authorized status under TRICARE and has been reinstated as outline in Section 6.

9.2 The contractor shall notify the provider, pharmacy, or entity in writing of the proposed action to terminate them. The contractor shall specifically notify the provider, pharmacy, or entity of the proposed action to terminate their status as an authorized TRICARE provider when the provider, pharmacy, or entity falls within the contractor's certifying responsibility and the provider, pharmacy, or entity fails to meet the requirements of 32 CFR 199.6 (Addendum A, Figure 13.A-9). The provider, pharmacy, or entity is not to be terminated when he/she fails to return certification packets. Such

providers will be flagged as "inactive." (Do not send a copy of the proposed notice to DHA PI.) The notice will be sent to the provider's, pharmacy's or entity's last known business/office address.

Note: The pharmacy contractor shall notify the pharmacy in writing of the proposed action to terminate the pharmacy status as a network pharmacy when it is not in compliance with its agreement and the pharmacy fails to meet the requirements of 32 CFR 199.6 (Addendum A, Figure 13.A-9).

9.2.1 The notice shall state that the provider, pharmacy, or entity will be terminated as of the effective date of the termination notice. The notice shall also inform the provider, pharmacy, or entity of the situation(s) or action(s) which form the basis for the proposed termination.

9.2.2 For network providers, the notice shall inform the provider that his/her patients will be referred to another provider pending final action. For a network pharmacy, the notice shall inform the pharmacy that beneficiary prescriptions may not be filled and any claims submitted will be denied.

9.2.3 The notice shall offer the provider, pharmacy, or entity an opportunity to respond within 30 calendar days from the date of the notice. An extension to 60 calendar days may be granted if a written request is received during the 30 calendar days showing good cause. The provider, pharmacy, or entity may respond with either documentary evidence and written argument contesting the proposed action or a written request to present in person evidence or argument to a contractor's designee at the contractor's location. Expenses incurred by the provider, pharmacy, or entity are their responsibility.

9.2.4 Once the notice of proposed action to terminate is sent, the provider's claims will be suspended from claims processing until an Initial Determination is issued. The provider, pharmacy, or entity will be notified via the proposed notice that the claims will be suspended from claims processing. However, beneficiaries will not be notified of the suspension.

9.2.5 For pharmacy claims, once the notice of proposed action to terminate is sent, the pharmacy's claims will not be processed as network claims until an Initial Determination is issued. The pharmacy will be notified via the notice that the claims will not be processed as network claims. Beneficiaries will be advised by the pharmacy that it is no longer a network pharmacy and that any prescription filled there will require submittal of a claim for reimbursement by the beneficiary.

9.2.6 If the provider being terminated is a Primary Care Manager (PCM), the contractor shall assist Prime enrollees with selecting a new PCM. The contractor is also responsible for assuring that the patient's medical records are transferred to the new PCM. Efforts shall be taken to notify non-TRICARE Prime beneficiaries in a cost-effective manner.

9.3 Initial Determination

If after the provider, pharmacy, or entity has exhausted, or failed to comply with the procedures for appealing the proposed termination and the decision to terminate remains unchanged, the contractor shall invoke an administrative remedy of termination. The contractor shall accomplish this by issuing a written notice of the Initial Determination via certified mail to the effective entity. A copy of the Initial Determination shall be sent to DHA PI along with supporting documentation The Initial Determination written notice shall include the following:

- A Unique Identification Number (UIN) indicating the fiscal year of the Initial Determination, a consecutive number within that fiscal year and the contractor's name. A sample letter is

found at Addendum A, Figure 13.A-10.

- A statement of the action being invoked and the effective date of the action. The effective date shall be the date the provider, pharmacy, or entity no longer meets the regulatory requirements. If there is no documentation the provider ever met the requirements, the effective date will be either June 10, 1977 (the effective date of the Regulation) or the date on which the provider, pharmacy or entity was first approved, whichever date is later. In the case of a pharmacy, it would be the date on which the pharmacy first became part of the network.

- A statement of the facts, circumstances, and/or actions that forms the basis for the termination and a discussion of any information submitted by the provider, pharmacy, or entity relevant to the termination.

- A statement of the provider's, pharmacy's, or entity's right to appeal.

- The requirements and procedures for reinstatement.

- A copy of the Initial Determination will be sent to DHA PI along with supporting documentation.

9.4 Providers Failing To Return Recertification Documentation

Providers, pharmacies, or entities failing to return recertification documentation shall not be terminated but will be placed on the "inactive" provider listing. The contractor shall first verify that the recertification package was mailed to the correct address and was not returned by the U.S. Postal Service (USPS). The provider's file shall be flagged to deny claims for services regardless of who submits the claim. The provider, pharmacy, or entity shall be advised that such action will be taken. Refer to Section 3 regarding development of possible fraud/abuse cases.

9.5 Requirement To Recoup Erroneous Payments

After the Initial Determination has been sent, the contractor shall initiate recoupment for any claims cost-shared, paid for services, or supplies furnished by the provider (or pharmacy for any previously paid claims for pharmaceuticals or supplies furnished by the pharmacy) or entity on or after the effective date of termination, even when the effective date is retroactive, unless a specified exception is provided by 32 CFR 199. This applies to claims processed by previous contractors as well. All monies paid by previous contractors and recouped by the current contractor will be refunded to DHA Finance and Accounting Office (F&AO). Refer to Chapter 3.

9.6 File Requirements For A Terminated Provider, Pharmacy, Or Entity

The Initial Determination file for the provider, pharmacy, or entity shall include the following documentation:

- Initial Determination of Termination Action as well as Proposed Notice to Terminate.

- Provider certification file (i.e., the documentation upon which the original certification of the provider was based) or network pharmacy agreement.

- All correspondence and documentation relating to the termination (copies of the enclosures must be attached to the copy of the original correspondence).

- Documentation that the contractor considered or relied upon for issuing the determination.

9.7 Special Action/Notice Requirements When An Institution Is Terminated

When a DHA determination is made that an institutional provider does not meet qualifications or standards to be an authorized TRICARE provider, the contractor shall take appropriate action.

9.7.1 Provider And Beneficiary Notification

The contractor shall:

- Instruct the institution by certified mail to immediately give written notice of the termination to any TRICARE beneficiary (or his/her parent, guardian, or other representative) admitted to or receiving care at the institution on or after the effective date of the termination.

- When the termination effective date is after the date of the initial determination, notify any beneficiary (or their parent, guardian, or other representative) admitted prior to the date of the termination by certified mail that TRICARE cost-sharing ended as of the termination date. Advise the beneficiary (or their parent, guardian, or other representative) of their financial liability. The contractor shall also use a fast, effective means of notice (e.g., phone, fax, express mail, or regular mail, depending on the circumstances.).

- If an institution is granted a grace period to effect correction of a minor violation, notify any beneficiary (or his/her parent, guardian, or other representative) admitted prior to the grace period of the violation that TRICARE cost-sharing of covered care will continue during that period. (Cost-sharing is to continue through the last day of the month following the month in which the institution is terminated.)

- In addition, notify any beneficiary (or their parent, guardian, or other representative) admitted prior to a grace period of the institution's corrective action, when such has been determined to have occurred, and the continuation of the institution as an authorized TRICARE provider.

- For a beneficiary admitted during a grace period, cost-share only that care received after 12:01 a.m., on the day written notice of correction of a minor violation was received or the day corrective action was completed.

9.7.2 Cost-Sharing Actions

The contractor shall deny cost-sharing for any:

- New patient admitted after the effective date of the termination.

- Beneficiary admitted during a grace period granted an institution involved in a minor violation.

- Beneficiary already in an institution involved in a major violation beginning with the effective date of the termination.

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